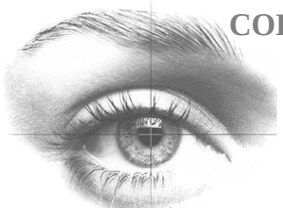


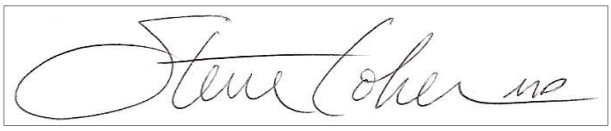
COHEN OPHTHALMOLOGY
STEVE COHEN, M.D.

It is with great pleasure and true appreciation that I welcome you to my office, As of January 2012 we will be located at 6528 E. Carondelet Dr. Tucson, Arizona 85710.

Our office is open from 7:45am to 4:30pm Monday through Thursday and 7:45am to 3:30pm on Fridays.

Cohen Ophthalmology was established to provide patients with excellence in eye care. We will continue to provide a warm and friendly office with state-of-the-art technology that has been created for your comprehensive eye care needs. As an innovator and leader in the ophthalmic community, I will provide only the best care with compassion and trust.

Best regards,



Steve Cohen, M.D.

COHEN OPHTHALMOLOGY
PATIENT REGISTRATION

Patient Name (Last):_____ First: _____ Int: _____

Address: _____ Apt #:_____City, State & Zip: _____

Home Phone: _____Work Phone: _____DOB: _____

Patient Social Security #: _____ Male___ Female___ Marital Status: M___S___ D___ W___

Patient Employer: _____Address: _____

Occupation: _____ Work Status: _____ Student Status: _____

Your Primary Care Doctor (First/last name): _____Phone#_____

Responsible Party Name: _____Relationship to Patient: _____

Responsible Party Social Security # _____DOB: _____

How will the bill be paid today? _____

EMERGENCY CONTACT: _____**PHONE #** _____

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: Employer: _____

Policy Number: _____Group Number: _____

Co-pay: _____ Deductible: _____

Effective Date of Coverage: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay: _____Deductible: _____

Effective Date of Coverage: _____

Where did you hear about Dr. Cohen?_____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Cohen Ophthalmology & Consulting authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions

Signature: _____ Date: _____

Cohen Ophthalmology
Financial Policy

Welcome to our office! We are pleased that you have chosen Dr. Steve Cohen to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept credit cards, cash and personal checks for payment on your account. If you have insurance which we do not contract with, you will be expected to make a full or partial payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay at the time of your visit.

COMMERCIAL/PRIVATE INSURANCE: As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card, photo ID and all necessary billing information. If you owe on your deductible or owe co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

CONTRACTED INSURANCE: We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

_____**In the event Dr. Cohen is not contracted with your health plan, you will be responsible**
Initial here **for any out of network, coinsurance, or deductible applied.**

NO INSURANCE: If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

MEDICARE: We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance at the time of service.

NO SHOW FEE: In the event your appointment is not canceled 24 hours in advance and/ or you do not show for your appointment, there will be a $25.00 fee assessed to your account.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a $25.00 return check fee charged to your account.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Cohen Ophthalmology & Consulting Inc and have provided to the best of my ability the information requested accurately and completely.

_____ _____

Patients/Responsible Party Signature Date

Cohen Ophthalmology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of Cohen Ophthalmology Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement,** but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____

COHEN OPHTHALMOLOGY

Medical History

Date: _____

Patient Name: _____ DOB: ____/____/_____

Primary Care Physician: _____ Referring Doctor_____

MEDICATIONS TAKEN	REASON

PAST MEDICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	SURGERY/PROCEDURE

MEDICATION ALLERGIES	REACTION

LATEX ALLERGY: □ Yes □No
SPECIAL ACCOMODATIONS: □ Wheelchair accessible room □ I need an interpreter
□Other_____

FAMILY HISTORY: DIAGNOSIS	FAMILY MEMBER

SOCIAL HISTORY

TOBACCO USE: □Yes □No □Former
Type___ Years used____Year quit____
□ Current daily smoker □ Social smoker

DRINKS ALCOHOL □Yes □No □Former
Frequency_____
CAFFIENE □Yes □No Type_____

COHEN OPHTHALMOLOGY

Ocular History

Patient Name: _____ DOB: ____/____/_____

Reason for today's visit:_____

_____

_____

Please be aware dilation is required for all new patient comprehensive eye exams. If you are here for a new or updated glasses/ contact lens prescription, there is a $40.00 service charge that is due at the time of your visit.

Optometrist name/Previous Ophthalmologists name:_____

Date of last eye exam:_____ □ I have never have seen an eye specialist

Do you wear glasses? □ Yes □No Do you wear contacts? □ Yes □No

If you wear contacts please list brand, type of contacts and prescription:

_____

Are you currently experiencing any eye symptoms? Please circle all that apply

Eye pain	**Blurred vision**	**Eyelid crusting**	**Flashes of light**	**Halos**
Discharge	**Light sensitivity**	**Double vision**	**Decrease in vision**	**Floaters**

Have you ever had an eye injury? If yes please describe

_____

_____

Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____R/L_____

_____R/L_____

Are you currently using eye drops, eye wash or eye vitamins? List name and how often used

_____

_____

_____

FAMILY HISTORY

Please check the boxes that apply if any of your immediate family members have/had any of the following conditions:

	Father	Mother	Brother	Sister
Glaucoma	□	□	□	□
Retinal Detachment	□	□	□	□
Bleeding Tendency	□	□	□	□
Macular Degeneration	□	□	□	□

Other not listed: _____

Preferred Pharmacy Selection

Please indicate your preferred pharmacy (ies) for any medications we may prescribe:

Pharmacy Name	
Address and/or cross streets	
Phone number	

Pharmacy Name	
Address and/or cross streets	
Phone number	

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system to improve the quality of our services. This system also allows us to collect and review your "medication history". A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give permission to collect, and give pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. This medication history is a useful guide, but it may not completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for COHEN OPHTHALMOLOGY to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

_____

Patient Name

_____ _____

Patient or Parent/Guardian Signature Date