FERNANDO TRUJILLO, MD

AMERICAN BOARD CERTIFIED OPHTHALMOLOGIST

CORNEA AND REFRACTIVE SURGERY

NEW PATIENTS INFORMATION (INFORMACION PARA EL NUEVO PACIENTE)

Date (*Fecha*): ________________

Name (*Nombre*): ____

Age (*Edad*): ____________ **Date of Birth** (*Fecha de Nacimiento*): ___________________________________

SSN (*Seguro Social*):_______--_____--_________**Sex** (*Sexo*):______**Marital Status** (*Estado Civil*): S M D W

Primary Language (Idioma):______________**Ethnicity** (Etnicidad): Hispanic or Latino / Nonhispanic or Latino

Race (Raza): White/ African American/American Indian/Asian/Hispanic/Latino/ Other

Address (Domicilio):____

City (*Ciudad*)________________________________**State** (*Estado*)__________ **Zip** (*C.P.*)_______________

Primary Phone (*Telefono primario*):__________________________ Home/Cell /Work/ Other(Casa/ celular/ Trabajo)

Secondary Phone (*Telefono secundario*): ______________________ Home/Cell /Work/Other(Casa/ celular/ Trabajo)

Email Address (Correo Electronico): ____

<u>**Responsible Party Name**</u> (Persona Responsable):____

Address (*Domicilio*):____

Phone (Telefono):_______________________**Relation to Patient** (Relacion con el paciente):___________

DOB (Fecha de nacimiento):____________________ **SSN** (Seguro social):_______________________

<u>**Pharmacy Name**</u> (Nombre de la Farmacia):_______________________ Phone # (Telefono):_________________

Location (Ubicacion):____

<u>**Primary Care Doctor**</u> **(Doctor Primario**):____

Phone # (Telefono):___________________________

<u>**Name of Referring Doctor**</u> **(Nombre del Dr que lo refirio**):____

Phone # (Telefono): _________________________

<u>**Drug Allergies (Alergia a alguna medicina**</u>): ____

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HIPAA Patient Questionnaire

Cuestionario de HIPAA Para los Pacientes

Please list the a family member or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations). (As a reminder these will be the only people we will be able to speak to or release any information to regarding your account.)

Indique los miembros de la familia u otras personas, en su caso, a quien podemos informarle sobre su estado de salud general, su diagnóstico y las preguntas sobre facturación (incluyendo las operaciones de tratamiento, pago y operaciones de atención médica). (Cabe recordar que estas serán las únicas personas vamos a ser capaces de hablar o dar cualquier información al respecto a su cuenta.)

Name (Nombre): ______________________________________ Phone #: ___________________

Name (Nombre): ______________________________________ Phone #: ___________________

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? *(¿Pueden dejar los mensajes confidenciales (por ejemplo, recordatorios de citas) en el contestador automático de teléfono o correo de voz?)* **YES (Si) / NO (No)**

Please indicate if we may mail your appointment reminder/recall postcard via the mail? (*Por favor, indique si se nos permite enviar su postal recordatorio de la cita a través del correo?)* **YES (Si) / NO (N0)**

This form will remain in effect until you make any changes in writing. (*Esta forma se mantendrá en efecto hasta que se haga algún cambio escrito).*

I am aware of the notice of privacy practice and will ask for a copy, if needed

Patient Name Printed (Nombre del Paciente): ____

Patient Signature (Firma del paciente):____________________________________ Date (Fecha):__________

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Financial Policy

INSURANCE AND PAYMENTS

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a part of that contract.
- By signing the Financial Policy, I am authorizing my insurance benefits to be paid directly to 3 C Vision Specialists. I understand that I am financially responsible for my deductibles, co-insurance, copays, or procedures deemed as non-covered services, I also authorize 3 C Vision Specialists to release any information required to process my claim.
- All charges are your responsibility whether the insurance company pays or does not pay. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Payments for services as well as unpaid deductibles and copayments are due at the time services are rendered.
- If your insurance doesn't pay, we require that you pay the balance by cash, check, or any major credit card. All unpaid charges are your responsibility.
- Personal checks returned for non-sufficient funds, will result in a returned check fee of $35.00 to be assessed to your account. You will need to provide an alternative method of payment for future visits.
- **3 C Vision Specialists DOES NOT ACCEPT VISION PLANS**.
  - If you see Dr. Trujillo and you **DO NOT** have a medical diagnosis, the visit is consider a routine vision exam and if you **DO NOT** have medical insurance with routine vision coverage or you are participate in a vision plan you will be responsible for charges incurred.
  - **Refractions: The Medical testing that is performed to get the prescription for glasses.** Refraction is the process of determining the eye's refractive error, or need for corrective lenses. However, it is considered a non-covered service by Medicare and most insurance companies; thus, it becomes the responsibility of the patient to pay for the refraction charge. Our fee for the refraction is $35.00 and is collected at the time of the visit, in addition to any copayment or deductible or balance due from the medical portion of your examination.

PRIVATE PAY

- You will be responsible for all charges to be paid in full at the time of services.

CANCELLATIONS AND NO SHOWS

- Any appointment missed or not canceled at least 24 hours in advance will be charged **$35.00** for inconvenience fee.
- Repeated cancellations rescheduled appointment or no shows my result in termination from practice.

I have read the above information and understand the financial policy, refraction policy, and cancellation and no show policy. I accept full financial responsibility for the cost of these services.

PATIENT NAME: ______________________________________ **DATE:** ____________________

PATIENT SIGNATURE: ____