Biltmore
EYE PHYSICIANS, P.C.

ROBERT BULLINGTON JR., M.D.
Eye Physician and Surgeon
Cataract, Cornea, and External Disease

AILEEN VILLAREAL, M.D.
Eye Physician and Surgeon

BETHANY WONG, O.D.
Optometrist

Included in our new patient packet are the following items:

1. Patient Registration
2. Notice of Privacy Practices
3. Financial Agreement
4. Medical History

Please fill out each form completely and accurately and bring the completed forms with you to your first appointment. We also ask that you please bring your most current pair of glasses, and if you are a contact lens wearer, please bring your contact lens prescription as well.

Please be aware that our physicians participate with *most* Blue Cross/Blue Shield and United Healthcare medical insurance plans. Should your insurance carrier require a referral (the front of your insurance card will indicate this), you should obtain one from your primary care provider prior to your first visit to avoid financial penalties. For those patients who are insured by other insurance plans and who wish to submit a claim, we are happy to provide an itemized receipt to facilitate the process or to bill your carrier as a courtesy, if desired.

We look forward to serving you and your eye care needs. Please do not hesitate to contact our office if we can be of any further assistance.

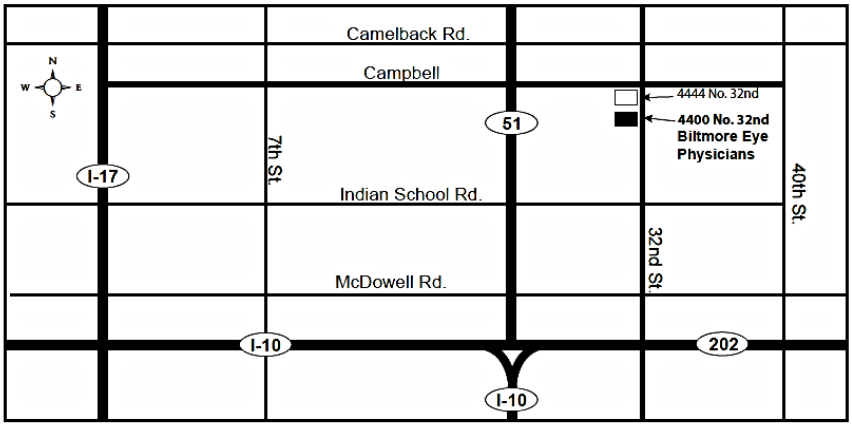
Sincerely,

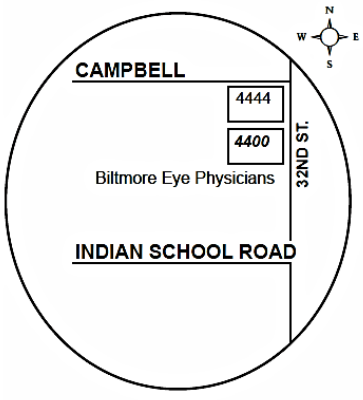
The Physicians and Staff of Biltmore Eye Physicians

Please note: A $50.00 fee may be assessed if a patient does not give 24 hour notice when cancelling an appointment.

Biltmore Eye Physicians, P.C.
The Centre
4400 North 32nd Street, Suite 280
Phoenix, AZ 85018
(602) 266-6888

DIRECTIONS: *The office is located just **south** of Campbell **on the west side of 32nd Street.**
*See location below for assistance
Two bldgs, 4444 and 4400 North 32nd St.; we are in the 4400 bldg.
All parking spaces available, except for covered parking.





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Aileen F. Villareal, M.D.
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Biltmore Eye Physicians, P.C.
4400 N. 32nd Street
Suite #280
Phoenix, AZ 85018

Phone: (602) 266-6888
Fax: (602) 266-6895
Email: mail@biltmoreeye.com

Date: _____ Home Phone: _____

Cell Phone: _____

Name: _____ Email: _____
Last First MI

Street Address: _____
Street Apt # City State ZIP code

Mailing Address: _____
Street Apt # City State ZIP code

Birth Date: _____ Age: _____ Social Security Number (last 4 digits): _____

Employer: _____
Name Occupation Address

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F

Referral Source **(circle)**: Physician Online Insurance Patient: _____

Spouse or Parent's Name: _____
(if applicable)

Spouse or Parent's Employer: _____
(if applicable) Name Occupation Address

Referring Physician: _____
(if applicable) Name Phone Address (if known)

Primary Care Doctor: _____
Name Phone Address (if known)

Responsible Party: _____
(if applicable) Name Phone Relationship

In case of emergency, please contact: _____
Name Phone Relationship

INSURANCE INFORMATION

Primary Insurance Carrier: _____
(if applicable) Name Phone Relationship

Secondary Insurance Carrier: _____
(if applicable) Name Phone Relationship

ASSIGNMENT OF BENEFITS

I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to Biltmore Eye Physicians, P.C. A copy of this is as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by insurance. A claim will be filed for services provided, but coverage differs by plan and cannot be guaranteed.

Revocation: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I further release my physician from any liability arising from the release of information to the individual(s) agency designated herein.

Patient/Guardian's Signature: _____ **Date:** _____

Please present all insurance cards to the front desk.
The doctors participate with Blue Cross Blue Shield and United Healthcare only.
Routine eye exams that show no medical problems may not be covered by your insurance.

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Patient Privacy and Confidentiality
(Notice of Privacy Practices)

HIPAA (Health Insurance Portability & Accountability Act of 1996, a federal law) requires healthcare organizations to comply with specific rules regarding your **Protected Health Information** (PHI). Biltmore Eye Physicians operates within the confines of these rules, and has strict policies to respect patient privacy.

With my consent, Biltmore Eye Physicians, P.C. may use and disclose my protected health information (PHI) to carry out treatment, obtain payment, and to further healthcare operations. Please refer to our **Notice of Privacy Practices** (available from the front desk and our website under "Patient Forms") for a complete description of such uses and disclosures. If you have any questions, please contact the privacy officer of our practice by phone: *(602) 266-6888.*

Patient Name: _____ Date of Birth: _____

Address: _____
Street Apt. #

_____
City State ZIP code

I hereby acknowledge that I have been presented with a copy of Biltmore Eye Physicians' Notice of Privacy Practices or I have had the opportunity to review this information.

Patient/Guardian Signature: _____ Date: _____

I authorize Biltmore Eye Physicians, P.C. and its staff and/or representatives to communicate medical information pertaining to my care by the following methods:

Please check "Yes" or "No" and Write Telephone Number(s):

Home Telephone	☐ Yes	☐ No	Number: _____
Home Voicemail	☐ Yes	☐ No	
Work Telephone	☐ Yes	☐ No	Number: _____
Work Voicemail	☐ Yes	☐ No	
Cell Phone	☐ Yes	☐ No	Number: _____
Cell Voicemail	☐ Yes	☐ No	
Email	☐ Yes	☐ No	Email: _____

We will try to honor your above request. However, if there is no acceptable method to contact you regarding Protected Health Information, our office will not be able to contact you with information concerning your care. Therefore, you will have to schedule an office visit in order to discuss your results, whether normal or abnormal.

If you have a spouse, parent, caregiver, or other person with whom we may discuss your medical care, please list them below so our office has permission to share information with that/those person(s):

Spouse: _____ Parent: _____

Other: _____ Relationship: _____

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL AGREEMENT

- Biltmore Eye Physicians currently accepts *most* healthcare plans through United Healthcare and Blue Cross/Blue Shield. The providers do not contract with any other insurance plans. All the doctors in this office have opted out of the Medicare program, so neither the patient nor the physician may file a claim for any Medicare benefits. Please check with our billing office if you have a secondary group coverage that might be processed without Medicare.
- Each patient, *not his/her insurance company*, is responsible for the payment of all non-covered charges, deductibles and copays. Payment is expected at the time that services are rendered or contact lenses are dispensed, unless other arrangements are made in advance.
- **Routine eye examinations, in which there is no medical reason for the examination, may not be covered by your medical insurance**. It is *your responsibility* to know whether or not your insurance plan will cover the services that you receive in our office.
- **Fees for updating a glasses prescription or determining if glasses are needed (refraction) are often not covered by medical insurance and are therefore the patient's/guarantor's responsibility.**
- **Fees for contact lens fittings, contact lens refits, or contact lens evaluations are not covered by medical insurance and are the patient's/guarantor's responsibility.** A summary of fees for contact lens services is available upon request.
- Payment on all accounts billed is expected within 30 days. A $15.00 charge will be applied to your account for checks returned for insufficient funds. A $10.00 charge will be added to account balances over 60 days when transferred to an outside agency for collection. A service charge of 1.5% monthly will be accrued on all accounts outstanding over 90 days.
- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees if a delinquent balance is placed with a collection agency and/or attorney for collection or suit.

_____

Signature Date

Please complete entire form to the best of your ability.

NAME:

DATE:

DO YOU HAVE ANY MEDICAL PROBLEMS? YES NO
(if yes, circle applicable conditions)

ENDOCRINE: Diabetes Thyroid disease
CARDIOVASCULAR: Hypertension Heart disease Arrhythmia High Cholesterol Atrial fibrillation
MUSCULOSKELETAL: Osteoarthritis Fibromyalgia Chronic pain
RHEUMATOLOGIC: Rheumatoid arthritis Lupus Sjogren's
NEUROLOGICAL: Migraines Headaches Seizures Multiple sclerosis Dementia
ALLERGIC/IMMUNOLOGIC: Anaphylaxis HIV/AIDS Hay fever
SKIN: Rosacea Eczema Acne Rash Melanoma
EAR/NOSE/THROAT: Vertigo Hearing loss Tinnitus
RESPIRATORY: Asthma Emphysema COPD
GASTROINTESTINAL: Hepatitis A B or C Reflux Celiac disease
GENITOURINARY: Kidney disease Prostate disease
HEMATOLOGIC: Anemia Bleeding disorder Clotting disorder
PSYCHIATRIC: Depression Anxiety Bipolar disorder ADHD
CONSTITUTIONAL: Fever Fatigue Night sweats
CANCER (specify any):

PREVIOUS SURGERIES (list all eye surgeries and major procedures)

BLOOD THINNERS? YES NO (if yes, please circle)
Aspirin Vit E Coumadin Other (specify):

CURRENT MEDICATIONS (please include vitamins, supplements)

ALLERGIES TO MEDICATIONS? YES NO
(if yes, list name of drug and reaction)

OTHER CONDITIONS/DETAILS:

CIRCLE IF YOU HAVE: Pacemaker Defibrillator Stent

REACTIONS TO ANESTHESIA? YES NO
(if yes, list reaction here)

DO YOU HAVE ANY CURRENT EYE PROBLEMS? YES NO
(if yes, circle applicable conditions)

CATARACTS CATARACT SURGERY CORNEAL DISEASE
DRY EYE SYNDROME LASER/RK/CORRECTIVE SURGERY
GLAUCOMA MACULAR DEGENERATION
RETINAL PROBLEMS EYE INJURY LAZY EYE/CROSSED EYES

EYE DROPS (include over-the-counter medications, artificial

OTHER EYE PROBLEMS:

LIST FAMILY HISTORY FOR ANY EYE DISEASE (especially glaucoma, lazy eye, crossed eyes, cataracts, and retinal diseases)
Ex: "Father - glaucoma"

NAME OF PRIOR OPHTHALMOLOGIST/OPTOMETRIST:
NAME AND ADDRESS OF FAMILY PHYSICIAN:

DO YOU WEAR GLASSES? YES NO (if yes, please specify) DISTANCE READING BIFOCAL TRIFOCAL PROGRESSIVE

DO YOU WEAR CONTACT LENSES? YES NO
(if yes, please note brand, prescription, power if possible)

Contacts changed: (please circle) DAILY 2 WEEK MONTHLY
List method/brand of cleaning product:

SOCIAL HISTORY

TOBACCO USE: YES NO (circle, list details below)

ALCOHOL USE: YES NO (circle, list details below)

SUBSTANCE ABUSE: YES NO (circle, list details below)

Staff use only:

Patient (or Guardian) Signature: **Date:**