What to Expect at Your Appointment

All patients can expect to be treated respectfully throughout the course of their visit. Each patient will receive a thorough exam from our highly experienced Doctors and can also expect to have their needs assessed by our top notch Optical team when selecting eyewear. *It should be noted that all diabetic patients will be dilated.*

What to Bring to Your Appointment

Please bring the enclosed paperwork filled out in its entirety along with your insurance cards. It would also be helpful for you to bring your current eyeglasses (even if rarely used) and, if applicable, contact lens boxes that are currently prescribed to you. This will help our Doctors determine the best care for your eyes. If you would like to have your previous records sent to us, you may fill out a Release of Records form in our office and we will fax it to your previous eye care provider.

Patient Expectations

Payment for services is due at the time the services are rendered. This includes any co-pays that are applicable. Payment for materials, such as glasses or contacts, must be paid in full at the time of order. We accept many forms of payment which include Visa, Mastercard, Discover, American Express, Care Credit, cash and personal check.

Insurance

We are providers for most all major vision insurances including, but not limited to: VSP, Eyemed, Medicare, Medicaid, HIP 2.0, Avesis, and Spectera. We are also providers for most health insurances. Our team will do a complimentary benefits check for you and explain your benefits in detail upon your request. You will be expected to pay what is determined as not payable by your insurance for service and materials at the time of service.

Yaryan Eyecare Center Yaryaneyecare.com

Today's Date: _____

Patient Name: _____ Marital Status Single

Gender: Male ☐ Female ☐ Date of Birth: _____ Social Security Number: _____ _____

Street Address: _____City: _____State: _____ Zip: _____

Home #: _____Work #: _____Cell #:_____

Employer: _____ Occupation: _____

Can we get a hold of you via email? ☐ Yes ☐ No Email address: _____ _____

Can we get a hold of you via text? ☐ Yes ☐ No

RESPONSIBLE PARTY/MAIN INSURED/GUARDIAN

Name: _____ Date of Birth: _____ Social Security Number:_____

Street Address: _____City: _____State: _____ Zip: _____

Phone # _____Whom may we thank for referring you?_____

I authorize this office to release any information necessary to expedite processing insurance claims. I understand and agree I am personally responsible for all charges, regardless of insurance coverage for services and materials provided by Dr. K. Andrew Yaryan LLC. Insurance charges unpaid within sixty (60) days following the date of service will be transferred to the responsible party or patient. I understand and accept responsibility for service charges, late fees and other costs.

_____ _____

Patient Parent/Guardian (Responsible Party)

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a curren t copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X_____ OR X_____

Patient Signature Parent or Guardian (Responsible Party)

Patient Name: _____ Patient Date of Birth:_____

Primary Care Physician:_____ Phone:_____

Specialist Physician:_____ Phone:_____

Specialist Physician:_____ Phone:_____

(Specialist would include: Cardiologist, Neurologist, Endocrinologist, etc.)

List any medications you are currently taking (Prescription and/or over the counter):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have allergies to any medications? (Latex, Penicillin, Sulfa Drugs, etc.) Yes

If so, please list:

_____ _____

_____ _____

List all illnesses or injuries (Glaucoma, Diabetes, High Blood Pressure, Heart Attack, Stroke)

_____ _____

_____ _____

_____ _____

List any surgeries you have had (LASIK, cataract, Tonsillectomy, Appendectomy, Etc.)

_____ _____

_____ _____

_____ _____

Do any family members have any eye diseases (glaucoma, macular degeneration, retinal detachment, etc.)	No
Do any family members have diabetes, high blood pressure, high cholesterol?	Yes
Do you smoke? For how long? How much?	Yes
Do you drink alcohol? How much?	No

Patient Signature: _____ Date:_____

Parent or Gaurdian (Responsible Party) Signature: _____