THE EYE CLINIC

Farshid Paydar, MD - Board Certified Ophthalmologist
Joshua Miller, OD - Optometrist

PATIENT INFORMATION

PATIENT NAME_____ SPOUSE NAME_____

EMAIL: _____ By giving us your email address you are consenting to being registered on our patient portal

PATIENT BIRTHDATE_____ PATIENT GENDER (Circle One): Male Female

PATIENT SOCIAL SECURITY #_____ HOME PHONE_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

EMPLOYER_____ BUSINESS PHONE_____

GUARANTOR NAME_____ RELATIONSHIP_____

WHO REFERRED YOU? _____ PRIMARY CARE DOCTOR_____

CURRENT MEDICATIONS_____

_____

DRUG ALLERGIES_____

PRIMARY INSURANCE_____ SECONDARY_____

INSURED NAME_____

INSURED SOCIAL SECURITY #_____ INSURED BIRTHDATE_____

DO YOU SMOKE? Y N DO YOU DRINK? Y N DO YOU USE RECREATIONAL DRUGS? Y N

CHECK ALL MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

☐ HEART TROUBLE	☐ DIABETES	☐ BEEN DIAGNOSED WITH HIV
☐ HIGH BLOOD PRESSURE	☐ THYROID	☐ MACULAR DEGENERATION
☐ HIGH CHOLESTEROL	☐ GLAUCOMA	

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services such as co-pay, deductibles and fees not a benefit of my insurance plan.
Authorization to Release Information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

X_____
Signature (Patient or Parent if minor) **Date**

401 S. Calvary Way, Ste. D
Cottonwood, AZ 86326
PH: (928) 649-2600
FAX: (928) 634-7847

2155 W. St. Hwy 89A, Ste. 106
Sedona, AZ 86336
PH: (928) 203-9600
FAX: (928) 203-9601

6446 State Route 179, Ste. 209
Sedona, AZ 86351 (VOC)
PH: (928) 284-2459
FAX: (928) 284-2691

452 W. Finnie Flat Rd, Ste. A1
Camp Verde, AZ 86322
PH: (928) 567-3330
FAX: (928) 567-3359

The Eye Clinic and Same Day Surgery Center
Farshid Paydar, MD - Board Certified Ophthalmologist
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HIPAA NOTICE of PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS IFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities, include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As required by Law. Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity: and National Security: Workers Compensation: Inmates: Required Users and Disclosures: Under the Law, we must make disclosures to you and when requirements of Section 164-500.

Other Permitted and required uses and Disclosures will be made only with your Consent. Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us even if you have agreed to accept this notice alternatively I.E. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

This notice was published and becomes effective on or before **APRIL 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices.

_____

Patient Name

_____ _____

Signature **Date**

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REFRACTIVE EXAM ACKNOWLEDGEMENT

☆ *To be completed for all* ***Medical & Medicare Advantage Insurance*** *other than Traditional Medicare* ☆

Patient Name:_____

A Refractive Exam, also known as a Refraction is done to determine a new/updated prescription for glasses and or contacts. A refractive exam is vision related, so most medical insurances will not cover the service. Medical insurances deem this service as **"*Not Medically Necessary,"*** therefore it is an **optional service**. If services are declined your ***current prescription will not be renewed*** expiring 1 year after the issued date. If services are rendered there will be a ***$45.00*** **fee** for the refractive exam, due at time of service. In the event insurance is billed, you will be responsible for the ***$45.00*** **fee** if services are denied.

- **If you have vision coverage it is your responsibility to provide that information at check in. We cannot double bill medical and vision insurance for the same date of service. A separate appointment will need to be made for the refractive exam at a later date and time.**

Your signature below is ***only an acknowledgment*** that you have read and understand the fee associated with a Refractive Exam, **NOT** a consent for services.

_____ _____

Signature Date

Revised 6/2022- MG

The Eye Clinic

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Phone, Email, & Text Messaging Consent Form

We now provide our patients with the option to participate in our patient messaging communication system via Voice Reminder, Email, and or Text Message.
These features include:

- **Appointment Confirmation at the time an appointment is made**
  - ❖ Forgot the appointment card, we've got you covered.

Your appointment information will be automatically sent to you via Text or Email.

- **Appointment Reminders for upcoming appointment**
  - ❖ Receive a reminder 30 Days in advance if applicable

and the Day before your scheduled appointment

- **Appointment Notification for missed appointments**
  - ❖ Did you forget an appointment? No worries a reminder will be

sent to inform you of the missed appointment and to contact us to reschedule.

- **Appointment Recall Reminder to schedule your next appointment**
  - ❖ Are you due back for your annual eye exam? A reminder will be sent

30 Days in advance notifying you to contact our office to schedule an appointment.

PLEASE MARK ONE OF THE FOLLOWING:

☐ I wish to participate in the patient messaging communication system and by doing so I am consenting to receive appointment communications via Voice Reminder, Email, and or Text Message *(Text messaging or data rates may apply and The Eye Clinic is not responsible for any fees.)* I understand I can withdraw my consent at any time by informing front office staff. Please select the preferred method or methods of communication below. If no preferred method of communication is selected you will automatically default to a Voice Reminder to the number on file.

I consent to receive appointment communications via:

- ☐ **Voice Reminder** (automated phone call), my phone number is: _____
- ☐ **Email**, my Email address is: _____
- ☐ **Text Message**, my cell phone number is: _____

☐ I do not wish to participate in the patient messaging communication system and do not consent to receiving any information via Email or Text Message and understand I will not receive Voice Reminders either unless requested.

Please sign below to indicate that you agree to allow us to use this information in providing your services. You may choose to discontinue your participation in our patient messaging communication system at any time by notifying front office staff.

Print Name: _____

Signature: _____ Date: _____