

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 INFORMATION. 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 or 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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MEDICARE AUTHORIZATION

☆ *To be completed if Medicare is the Primary Insurance* ☆

Patient Name: _____

I request that payment under The Medical Insurance Program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I authorize the above-named provider to release to the Social Security Administration or Intermediaries or Carriers any information needed for this claim or a related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

REFRACTION EXAM:

Medicare requires that we inform you when we perform a procedure that they do not cover. Medicare along with most major insurances do not cover a Refraction. A Refraction is the portion of the exam which determines the prescription for the eyeglasses or whether you need a change in your glasses. With this notification you are aware that you be responsible for the Refraction Fee in the amount of \$45.00 at the time of service.

✱ *If you have vision insurance and wish to have a vision exam, please notify the front desk before being seen.*

Signature

Date



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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: _____