PROVIEW
EYE CARE OPTOMETRY
See Better | Look Better | Feel Better

Patient Information

◯ Dr. ◯ Mr. ◯ Ms. ◯ Mrs. Name_____Date_____

Date of birth_____Age_____Gender ◯ Male ◯ Female

Address_____City_____State_____Zip_____

Home phone_____Mobile phone_____Text messaging ok? ◯ Yes ◯ No

Email_____Occupation_____

**Primary reason for today's visit:*_____

**Any problems with your current glasses and/or contact lenses?*_____

_____

**How did you hear about us?* ◯ *Social Media* ◯ *Insurance* ◯ *Family/friend, who?*_____ __

◯ *Doctor referral* ◯ *Other:*_____

Patient Medical History

Name of family physician_____
Date of last physical check up_____
Medical insurance_____

◯ HMO ◯ PPO ◯ I do not have medical insurance

Current medical illnesses:_____

_____

_____

Current medications (including eye drops):

_____

_____

Allergies to medications? ◯ Yes (list below) ◯ No

_____

_____

Patient Ocular History

Name of last eye doctor_____
Date of last eye exam_____

Any eye surgery or injury? ◯ Yes (list below) ◯ No

_____

_____

Check all that apply:

Disease/Condition	Self	Family	Relationship to you
Blindness	◯	◯	
Cataract	◯	◯	
Lazy eye	◯	◯	
Glaucoma	◯	◯	
Macular Degeneration	◯	◯	
Retinal Detachment	◯	◯	
Diabetes	◯	◯	
High Blood Pressure	◯	◯	
Lupus	◯	◯	
Rheumatoid Arthritis	◯	◯	
Cancer	◯	◯	

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VISION AND MEDICAL INSURANCE POLICY

When your insurance provider(s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage. Unpaid balances are the sole responsibility of the patient.

The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider. Any patient portion amounts on your order will be due at the time of service.

I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

REFUND/RETURN POLICY

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds or exchanges for frames and frame accessories can only be made within thirty (30) days of receiving the product, provided the product is returned to the store without damage at the time that the refund is issued. Eyeglass lenses are a custom-made item, therefore they are non-refundable and once ordered cannot be canceled. Unopened boxes of contact lenses may be exchanged within thirty (30) days of purchase. Opened boxes of contact lenses are non-refundable or exchangeable. Any orders not picked up within ninety (90) days are returned and deposits are forfeited, unless other arrangements have been made.

CONSENT FOR TREATMENT

I hereby authorize Alan A. Arabi, O.D., Inc. to administer diagnostic and medical procedures as may be necessary for proper health care.

I have read and understood the *Vision and Medical Insurance Policy, Refund/Return Policy*, and accept the *Consent for Treatment*.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Authorized representative's name Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative of the Patient, acknowledges that he or she personally received a copy of the Alan A. Arabi, O.D., Inc., ProView Eye Care Optometry, Notice of Privacy Policies on the date indicated below:

_____ _____

Signature of patient or authorized representative Date

_____ _____

Authorized representative's name Relationship

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice). We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

How Your Health Information May Be Used

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

Notice Of Privacy Practices

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures.The listing is below.

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose. We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

PATIENT RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
  800 Magnolia Avenue Suite 113, Corona, CA 92563
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information was not created by us, unless the person that created the information is no longer available to make the amendment, is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy, or is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.
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Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is: Alan A. Arabi, O.D.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. If you would like a paper copy please ask the front desk. At any time you may call and we will mail or email a copy to you.
We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice when requested. You have the right to express complaints to us or to the U.S. Department of Health and Human Services, Office for Civil Rights if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Notice Revised and Effective: April 4, 2019