The Woolf Eye and Laser Clinic, Ltd. Patient Information Form

Patient's Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____ Referred By _____
First Middle Initial Last

Complete Mailing Address: _____
Street Apt. or Space No. City ZIP

Home Phone: ( )_____ Cell: ( ) _____ Business Phone: ( )_____
Birthdate: _____ Age: _____ Occupation: ☐ Retired _____
Month Day Year

Social Security#: _____ Driver's License #: _____ State _____
(Parent's if Child is a Minor)

Emergency Contact Name: _____ Relationship: _____ Phone: _____
Employer: _____ Employer's Address: _____
Spouse's OR Parent's Full Name: _____
Spouse's OR Parent's Employer: _____
Spouse's or Parent's Employer's Address: _____

Primary Insurance; _____ ID #: _____ Group #: _____
Primary Insurance Address: _____
Name of Insured Person(s): _____ Date of Birth _____
Secondary Insurance: _____ ID #: _____ Group #: _____
Name of Insured Person(s): _____ Date of Birth _____

MEDICAL HISTORY

Primary Care Physician: _____ Office Phone Number: _____
Last Exam: _____ Months Ago _____ Years Ago
Do you wear Glasses? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No Are you sensitive to light? ☐ Yes ☐ No
Are you active in sports? ☐ Yes ☐ No Are you having problems with your present eyeglasses or contact lenses? ☐ Yes ☐ No
If yes, please explain: _____
Do you work at a computer terminal? ☐ Yes ☐ No Hours Per Day at the Terminal _____
What Type of lenses, Mark all that apply: ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Varilux ☐ Zeiss ☐ Panamic ☐ Generic

Social History: ☐ Smoking ☐ Alcohol Use ☐ Vitamins ☐ Herbal Supplements
Check if you have ever had any of the following:
☐ Cataracts ☐ Blindness ☐ Retinal Detachment ☐ Stroke ☐ Glaucoma ☐ Lazy Eye-Crossed Eye
☐ High Blood Pressure ☐ Diabetes ☐ Macular Degeneration ☐ Other Eye Disease(s)-Specify _____
☐ Eye Surgery-Specifiy _____ ☐ Previous Eye Injury-Specify _____
☐ Allergies or Reactions to ANY Medications-Specify _____

Check if any of your BLOOD RELATIVES have ever had any of the following:
☐ Cataracts ☐ Blindness ☐ Retinal Detachment ☐ Stroke ☐ Lazy-Eye-Crossed Eye
☐ High Blood Pressure ☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma
☐ Other Eye Disease(s)-Specify _____

List ALL Medications you are currently using: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize release of any medical information necessary to process claims and request payment of benefits either to myself or to the party who accepts assignment. I also accept full responsibility for the cost of ALL Professional Services rendered to the above named patient including responsibility for amounts not covered by insurance. I have read, understand and accept all aspects of the Financial Policy of the Woolf Eye and Laser Clinic, Ltd. Described on the following page.

Name: _____ Date: _____

WOOLF EYE AND LASER CLINIC, LTD.

COMPREHENSIVE OPTHALMOLOGY
LASER VISION CORRECTION
COSMETIC LASER SURGERY
ADVANCED CATARACT SURGERY

WILLIAM A. WOOLF M.D.
BOARD CERTIFIED

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

By signing this form I am designating the party below with whom I wish Woolf Eye & Laser Clinic to be able to discuss my medical condition.

_____
Name

_____
Relationship

_____
Name

_____
Relationship

_____
Patient Signature

_____
Date

FINANCIAL POLICY OF THE WOOLF EYE AND LASER CLINIC, Ltd.

Please read carefully the financial policy below. We must emphasize that as a provider of medical care, our relationship is with You, not your insurance company. If you have questions relative to this policy, please ask, we are happy to provide clarification and any assistance you may need.

PAYMENT

1. Payment for cash services are due when services are rendered. Insurances will be billed.
2. If your insurance does not cover all fees, you are responsible for the difference*.
   a. *except for contracted adjustments the Woolf Eye and Laser Clinic has with specific health insurance providers.
3. All co-pays and the $36 refraction fee are due at the time of service. If you do not want to pay for a refraction, request that a refraction not be performed.
   a. Medicare and other insurance companies do not view refractions as medically necessary and are usually **NOT** covered under your insurance policy.
4. If your insurance is most likely to cover the fees associated with your visit, the insurance company will be billed by our staff, as a courtesy to you, and the co-pay and refraction fee will be collected at the time of service.
5. If there is a question on whether your insurance company will cover the fees, payment is due at the time of service. If you paid at the time of service and your insurance company subsequently covers the fees associated with the visit, you will be reimbursed within 30 days of the insurance reimbursement.

REFERRALS

6. **You are responsible to obtain ANY NEEDED REFERRAL from your insurance carrier**. If a referral is NOT obtained, you are responsible for full payment of services rendered.

CONTACT LENS EVALUATION FIT/RE-FIT and INITIAL PURCHASE OF CONTACT LENSES

7. Measurements are taken of the cornea to determine the base curve of the eyes along with the refraction to determine the best type and power of contact lenses for your eyes. There is a 3 month follow-up period to make sure that the lenses fit. Therefore your first lenses must be purchased through the office to guarantee a proper and healthy fit. No prescription can be written until the follow-up is complete.
8. Contact lens evaluation fit/re-fit fees are **NOT** covered by medical insurance. We are not contracted with any vision plans. The contact lens evaluation fit/re-fit fee is due at the time of exam.

CANCELLATION/MISSED APPOINTMENT POLICY

9. If you are unable to keep your scheduled appointment, it is your responsibility to notify our office at least 24 hours prior to your scheduled appointment time so that we can make that appointment time available for another patient. Failure to do so will result in a $25.00 charge to the patient. The patient will be responsible for this fee and it will not be billed to your insurance company.

_____ _____

Signature Date

Updated 9/8/2015

Refraction Policy

A **REFRACTION** is the process by which your eyeglass prescription is obtained.

Most insurance companies consider a REFRACTION "non-medical" and do not cover these charges.

You will be responsible for these charges. Our fee for the **REFRACTION** is **$36.00** due at the time of service.

By signing this you are stating that you have **read and understood our policy** about refractions.

This does not mean you are having a refraction today and have to pay the $36.00 fee.

If you have any questions please feel free to ask one of our staff. Thank you!

Signature:_____ Date:_____

Woolf Eye & Laser Clinic, Ltd.
2855 East Brown Road, Suite 10
Mesa, Arizona 85213
(480) 969-1000

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of Woolf Eye & Laser Clinic, Ltd. 'Notice of Privacy Practices'. This Notice describes how Woolf Eye & Laser Clinic, Ltd. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)

Woolf Eye and Laser Clinic, Ltd.
2855 East Brown Road, Suite 10
Mesa, Arizona 85213
(480) 969-1000

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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

CONTACT INFORMATION: If you have any questions about this notice, please contact Lynsey Woolf, Business Manager at (480) 969-1000 and/or 2855 E. Brown Road, Suite 10, Mesa, Arizona, 85213.

OUR DUTIES REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Take responsible steps to protect medical information that identifies you from unauthorized disclosure;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may 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 that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose medical information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when Dr. Woolf is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, and insurance company, or a third party. For example, we may need to give your health plan information about surgery you received, so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Appointment Reminders.** We may disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. It is our practice to leave a message on an answering machine if no one is home. It is also our practice to send out reminder cards in the mail if we cannot reach you by telephone.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family and friends your condition. In addition, we may disclose medical information about you to an entity in a disaster relief effort.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health.** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases.** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- Health Oversight Activities. We may disclose medical information about you to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.
- National Security and Intelligence Activities. We may release medical information about you to authorized federal officials; for intelligence, counterintelligence, and other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. If you revoke permission that was obtained as a condition of obtaining insurance coverage, other law still allows the insurance company to contest a claim under the policy.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you. Please feel free to discuss any questions with our staff.

- Right to Request Restrictions. You have the right to request, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare procedures. You may also request that any part of your personal health information not be disclosed to family members or friends who may be involved in your care. In certain cases we may deny your request for a restriction.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way. For example, you can ask that we only contact you at work or by mail.
- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.
- Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information for as long as we maintain this information. Your request must be made in writing and you must provide a reason that supports your request. In certain cases, we may deny your request for an amendment.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to Woolf Eye and Laser Clinic, Ltd., P.O. Box 31447, Mesa, Arizona, 85275-1447. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our Website, www.woolfeyemd.org. To obtain a paper copy of this notice, contact Lynsey Woolf, (480) 969-1000.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as, any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, the effective date. In addition, each time your come to our office for treatment or health care services, we will off you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a compliant. To file a complaint contact Lynsey Woolf, Business Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.