ViewFinder™
LOW VISION RESOURCE CENTER

_____ has an appointment on _____ at: _____
Name Date Check-In Time

Your appointment is with: ☐ Dr. Lynne Noon

Location:

- ☐ 10001 West Bell Road · Suite 115 · Sun City, Arizona 85351
  Phone: 623.583.2800
- ☐ 1830 South Alma School Rd. #7-131 · Mesa, Arizona 85210
  Phone: 480.924.8755
- ☐ Satellite Office: _____

Preparing for your low vision evaluation

This paperwork has been sent or given to you so that you can fill it out at home. Please arrive for your evaluation 10 minutes ahead of schedule and bring your ***completed paperwork*** and your ***insurance cards***. If you are unable to complete the paperwork at home, please arrive 20 minutes ahead of schedule and we will be happy to help you complete the necessary forms.

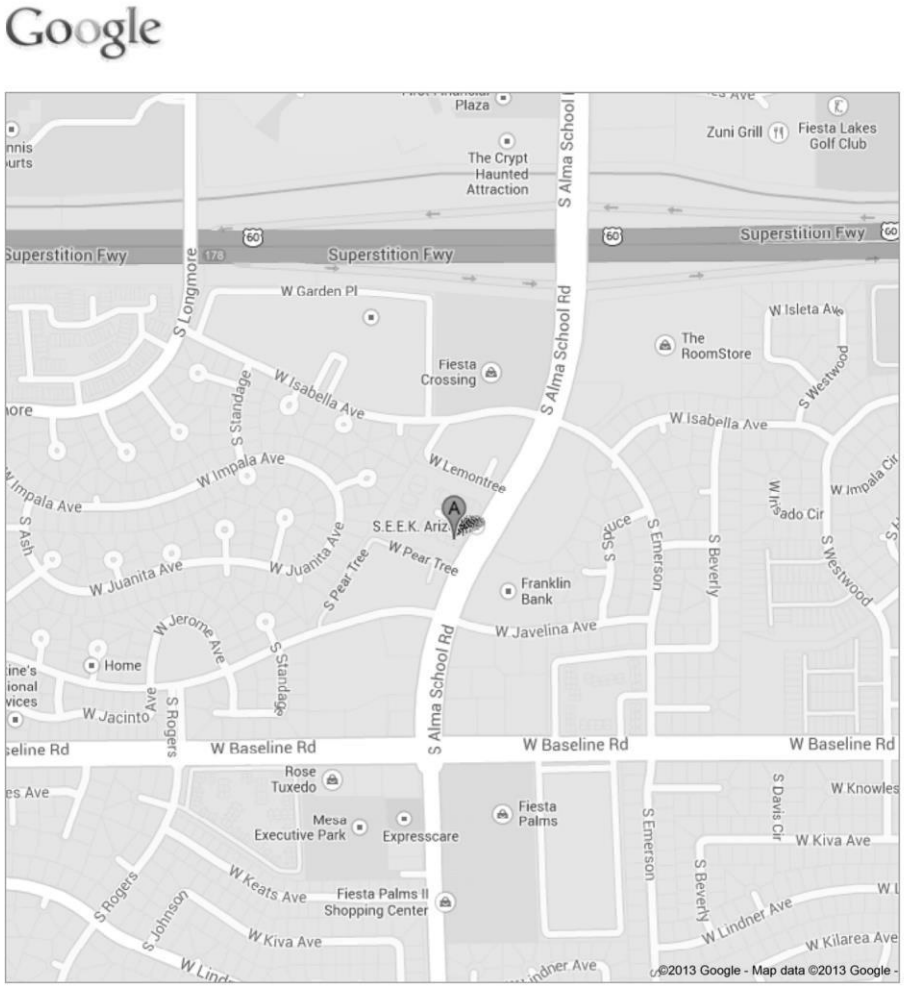
Please bring all current eyeglasses and easily transportable low vision aids to your appointment.

Because our doctors and occupational therapists often schedule up to an hour for each client, we ask that you let us know 24 hours before your appointment if you need to cancel or change your appointment time. We have a waiting list of patients who would love to move their appointment to an earlier date.

We charge $50.00 for all patient "no-show" appointments.

ViewFinder™
LOW VISION RESOURCE CENTER

10001 W Bell Road
Suite #115
Sun City, AZ 85351



ViewFinder™
LOW VISION RESOURCE CENTER

1830 S Alma School Road
Suite #131
Mesa, AZ 85210

ViewFinder™
LOW VISION RESOURCE CENTER

PATIENT REGISTRATION INFORMATION
PLEASE PRINT CLEARLY

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ *E-mail: _____

Date of Birth: _____/_____/_____ Male _____ Female _____

Social Security #: _____ Race: _____

***Referred by: _____**

***Where have you seen our advertising: _____**

_____

Emergency Contact: _____
Name Phone #

Legal Guardian Name/Power of Attorney:

_____

PLEASE BRING INSURANCE CARDS TO
EVERY APPOINTMENT

ViewFinder™
LOW VISION RESOURCE CENTER

CLIENT HEALTH HISTORY

Please check all that apply to you:

EARS/NOSE/THROAT:
___ Sinus problems
___ Allergies
___ Hearing loss

CARDIOVASCULAR:
___ Chest pain
___ Heart attack
___ Irregular heartbeat
___ Pacemaker
___ Heart murmur
___ Open heart surgery
___ Artificial heart valve
___ Cardiac arrest
___ High blood pressure

LUNGS:
___ Asthma
___ Emphysema
___ Shortness of breath
___ Tuberculosis
___ Chronic cough
___ Lung surgery
___ Lung cancer
___ Oxygen use

DIGESTIVE:
___ Ulcer
___ Intestinal problems
___ Diarrhea
___ Constipation

URINARY:
___ Chronic kidney infection
___ Kidney stones
___ Prostate problems
___ Frequent urination
___ Chronic bladder infection

LIVER:
___ Hepatitis
___ Jaundice

MUSCULAR/SKELETAL:
___ Arthritis
___ Joint Pain
___ Back problems
___ Arm weakness
___ Difficulty walking
___ Stroke

NERVOUS SYSTEM:
___ Stroke
___ Stroke affected vision
___ Head injury
___ Alzheimer's
___ Confusion
___ Dizziness
___ Multiple Sclerosis
___ Field defect
___ Depression

IMMUNE/ENDOCRINE:
___ Diabetes _____# of years
___ Thyroid (hypo/hyper)
___ Hypoglycemia
___ AIDS/AIDS related complex
___ Lupus

SOCIAL:
___ Tobacco use (past / present)
___ Alcohol abuse
___ Drug addiction

OTHER: _____
_____
_____
_____

PREVIOUS SURGICAL HISTORY: _____
_____
_____

OCULAR HISTORY:
___ Glaucoma R / L
___ ARMD R / L
___ Dry R / L
___ Wet R / L
___ Injections R / L
___ Cataracts R / L
___ Surgery R / L
___ Eye injury R / L
___ Retinal disease R / L
___ Strabismus R / L
___ Amblyopia R / L
___ Diabetes R / L
___ Dry eyes R / L
___ Other _____ R / L
___ Other _____ R / L

NAMES & DOSAGES OF ALL MEDICATION:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION ALLERGIES:
_____
_____
_____

ViewFinder™
LOW VISION RESOURCE CENTER
www.ViewFinderLowVision.com

Lynne Noon, OD, FAAO
Diplomate in Low Vision Rehabilitation

Corona Hoang, OD

We would like the names of your current eye doctors and primary care physician so that we may dictate a summary of this evaluation. Please list any other doctors that require a dictated letter.

Patient Name: _____ **Date:** _____

Current Eye Doctor: _____

Address: _____

_____

Current Retinal Specialist (or other eye specialist):

_____

Address: _____

_____

Primary Care Physician: _____

Address: _____

_____

Who else needs a summary (dictated letter) from this examination?

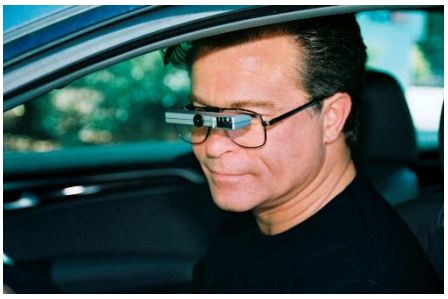
Name: _____

Address: _____

_____

ViewFinder™
LOW VISION RESOURCE CENTER

BE THE FIRST TO LEARN ABOUT NEW PRODUCTS, TREATMENTS & VISION REHABILITATION NEWS



If you would like to receive our quarterly newsletter, **ViewFinder E-News**, and would like to receive an emailed copy of our presentation **"Tips to Maintain Independence Despite Visual Impairment"** please enter your email below:

Email address:

_____

PLEASE PRINT CLEARLY

Additional Email Address:

_____

Search for ViewFinder Low Vision Resource Center on Facebook!
"Like" us to learn about promotions, product information, and news!

ViewFinder™
LOW VISION RESOURCE CENTER

FINANCIAL RESPONSIBILITY POLICY

Unless we are contracted with your insurance carrier, payment is due at the time of service. As a courtesy, we will bill your insurance on your behalf and will reimburse you, should your services be covered.

If you carry an HMO insurance policy along with Medicare, the HMO plan takes over as your primary insurance. HMO insurance policies MAY OR MAY NOT COVER low vision examinations. Please contact your HMO provider to discuss your covered benefits.

Your insurance coverage is a contract between you and your insurance company. Your doctor has no control over what is covered. You are responsible for knowing the benefits and restrictions of your insurance policy. Some insurance companies may not cover **"out of network"** services or **"non-participating provider"** services. **Your supplemental insurance may not pay the remaining balance of your charges, in which case the balance is your responsibility.**

A low vision examination normally includes a refraction. This is a test to determine the power of eyeglasses or other low vision devices you may need. The charge for this test is **$59.00** and is not covered by most insurances. **Please note that this is only a portion of the low vision exam and will be collected at the time of service.** The complete examination fee is determined by the amount of time the doctor spends with the patient and/or the tests performed.

By signing below, I acknowledge that I have read and understand the above Financial Responsibility Policy.

Signature: _____ Date: _____

DELINQUENT ACCOUNTS

By signing below, I acknowledge that in the event my insurance company does not pay for the services I receive, it is my responsibility to provide prompt payment to ViewFinder Low Vision Resource Center.

I understand that if my account becomes 60 days past due, ViewFinder will send my account to a collection company for resolution. All delinquent accounts that are sent to our collection agency will be increased in amount owed by 40% to cover our collection fees.

Signature: _____ Date: _____

INSURANCE AUTHORIZATION

I hereby authorize ViewFinder Low Vision Resource Center to release any medical information necessary to process my claim to my insurance company.

Signature: _____ Date: _____

PRIVACY POLICY AND CONSENT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

When you sign this consent document, you signify that you agree that we can and will disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. Under the privacy policy, we cannot disclose your information without your consent.

Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Print Name: _____

Relationship to Patient: _____ Date: _____

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.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

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 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

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.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- 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.

YOUR INDIVIDUAL 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.
- **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.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Dr. Lynne Noon
1830 S. Alma School Rd. #131
Mesa, AZ 85210
480.924.8755

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Viewfinder Low Vision Resource Center's , Notice of Privacy Practices.

Patient name_____

Signature _____ Date _____