Farnoosh Tinoosh M.D. FAAO, FABHP
Universal Vision Medical Center
1503 South Coast Drive Suite 120
Costa Mesa, CA 92626
(714) 424-9955

PATIENT REGISTRATION FORM

PLEASE FILL OUT COMPLETELY AND BRING YOUR PHOTO ID & MEDICAL INSURANCE CARDS
Please Use Black Ink ONLY

DATE: _____/_____/_____ **Preferred Language:** □ English □ فارسی □ Español

WHO SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Patient Information:

Name: _____ **Date of Birth:** ____/____/_____ **Age:** _____
(Last) (First)

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SS#: _____-_____-_____ **Email:** _____

Employed: □Yes □ No **Marital Status:** □ Single □ Married □ Divorce □ Widowed **Sex:** □ M □ F

Race/Ethnicity: □ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian/Other Pacific Islander □ White □ Iranian □ Hispanic/ Mexican □ Other: _____

Best way to contact you: □ Email □ Cell phone □ Txt □ Home Phone

Cell Phone: (_____) _____ **Home Phone:** (_____) _____

PCP (Family Doctor): _____ **Phone:** (_____) _____ **Fax:** (_____) _____

Pharmacy Name: _____ **Cross St:** _____ **Tel #:** (_____) _____

Emergency Contact: _____ **Phone:** (_____) _____ **Relationship:** _____

Medical/ Vision Insurance Information:

Whose name is the insurance under? □Self □ Other: _____ (Cont. Below)

Relationship: □Spouse □ _____ **Date of Birth:** ____/____/_____ SS #: _____

Primary Ins: □Medicare □Medical □Anthem □Bl-shield □Cigna □Aetna □Monarch □ _____

Secondary Ins: □Medicare □Medical □Anthem □Bl-shield □Cigna □Aetna □Monarch □ _____

Primary ID#: _____ **Secondary ID #:** _____

Vision Plan: □ None □VSP □ _____ **ID # or SS#:** _____

CONTINUE 

Patient Health History:

Do you smoke? □ YES: If yes, how long? _____ □ Years □ Months □ Weeks □ Days
□ NO: When did you quit: _____ □ Years □ Months □ Weeks □ Days

Do you wear contacts? □ YES: □ Hard □ Soft □ Disposable Last worn: _____ □ Years □ Months □ Days
□ NO

Do you wear glasses? □ YES: □ Single Vision □ Bifocal □ Trifocal □ Progressive
For how long: _____ □ Years □ Months □ Days
□ NO

Are you interested in LASIK? □ No □ YES, Please!

Are you interested in Cataract Consultation? □ No □ YES, Please!

Are you interested in new GLASSES / CONTACT LENS prescription? □ No □ YES, Please!
(Additional fee may apply for this service.)

Patient Ocular History:

	Yes	No
Glaucoma		
Cataract		
Lazy Eye		
Dry Eye		
Retinal Issues		
Eye Infections		
Eye Injury		
Cataract Surgery		
Laser Surgery		
Refractive surgery		
RK, AK, PRK, LASIK, CK		

Patient Medical History:

	Yes	No
Diabetes		
High Blood Pressure		
Cardiovascular Conditions		
Respiratory Issues		
Thyroid		
High Cholesterol		
Autoimmune Disease		
Headaches		
Ear		
Nose		
Throat		

	Yes	No
Currently Pregnant		
Lactating		
Arthritis		

List all allergies: □ No Allergies

_____

_____

_____

_____

_____

Family History:

	Yes	No
Glaucoma		
Cataract		
Lazy Eye		
Retinal Issues		
Blindness		

	Yes	No
Diabetes		
High Blood Pressure		
Cardiovascular Conditions		
Keratoconus		
Other		

Place a check next to any disease(s) you are currently taking medications for:

Diabetes □ Heart Disease □ Cholesterol □ Arthritis □ Hypertension □ COPD □ None □

Medications- List all additional medications you are currently using:

_____

_____

_____

CONTINUE 

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose 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). “Healthcare operations” mean those administrative and managerial functions that we have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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” who perform health care operations for us and who commit to respect the privacy of your health information;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

Continue

NOTICE OF PRIVACY PRACTICES
Continued

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. A fee of $25 will apply for Health Information Release. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review your health information within 5 days of asking us. You will be able to obtain a copy of health information within 15 days of asking us. You may have to pay for photocopies in advance, state law specifies that we may charge up to 25 cents per page. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the incorrect information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 or fax shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Continue

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Patient Insurance Responsibility Agreement

Dear Patient,

We are committed to providing you with the best possible care. If you have medical or vision insurance, we are committed to helping you receive your maximum allowable benefits.

When verifying benefits through our online clearinghouses, the information we receive from your insurance company is sometimes not always accurate. We encourage our patients to be familiar with their own insurance benefits.

Patients are responsible for payment at the time of service. You are responsible for any unmet deductible, coinsurance or copays and any non-covered services at the time services are rendered.

In order for us to file your claim in a timely manner a copy of your Medicare and/or insurance card will be needed as well as your referral from your primary care physician, if required by your insurance carrier.

Normal processing time takes 4-6 weeks for most insurance companies. We will make every attempt to work with your insurance company should they require additional information to process your claim. However, if your insurance company fails to make a payment within a reasonable length of time, issues a denial notice, and or goes into receivership, the balance will then be billed to you directly. A reasonable length of time is considered to approximately 5-6 weeks.

I agree to assume any financial obligation involved in the full payment of services, which include all outstanding balances not covered by Medicare and/or my insurance company. I authorize any holder of medical information to release to the Social Security Administration or its intermediaries or carriers, or to the billing agents of the insurance companies listed on my patient information record, or to my employer or worker's compensation carrier. Any information needed for this insurance or Medicare claim to be processed.

*We must emphasize that, as a medical care provider, my relationship is with you, not your insurance company. While filing of insurance is a **courtesy** we extend to my patients, all charges are your responsibility from the date the services are rendered.*

DR. TINOOSH RECOMMENDS CERTAIN SCREENING DIAGNOSTIC TESTS WHICH ALLOW HIM TO PERFORM A MORE COMPREHENSIVE AND THOROUGH EXAMINATION.

THESE TESTS INCLUDE: TOPOGRAPHY, RETINAL PHOTOS, MACULAR DENSITY, PACHMETRY AND OPTICAL COHERENCE TOMOGRAPHY – OCT. REFRACTIONS MAY OR MAY NOT BE COVERED BY YOUR MEDICAL/VISION PLAN. CONTACT LENS SERVICES, CONTACT LENSES, GLASSES, LASER VISION CORRECTION AND THE PREMIUM IMPLANTS FOR CATARACT SURGERY ARE NOT COVERED BY YOUR MEDICAL OR VISION PLANS.

***Any amount paid to Universal Vision Medical Center such as deposits, co-payments, installments etc. is non-refundable to its totality.**

***This agreement applies to both past AND future balances**

I have read the above and agree to abide by this written agreement. I understand that if I fail to meet my obligations, Dr. Tinoosh may take legal action to include a collection agency referral.

_____ I HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO READ IT.

_____ I authorize the release of any medical or other information necessary to process any insurance claim. I also authorize payment of medical benefits to Dr. Farnoosh Tinoosh, MD

_____ I UNDERSTAND THAT MY INSURANCE BENEFITS MAY OR MAY NOT COVER ANY OR ALL SERVICES.

_____ _____

Patient Signature **Date**