Print Form

DESERT EYE ASSOCIATES, LTD.

TUCSON AND GREEN VALLEY OFFICES

- ☐ Jack A. Aaron, M.D.
- ☐ Karl A. Rosen, M.D.
- ☐ Carmen L. Felix Tacoronte, M.D.
- ☐ James A. Parks, O.D.
- ☐ Zachary G. Pfau, O.D.

Appointment Date: _____

Appointment Time: _____

Last Name _____ First Name _____ Initial _____

Sex ◯ Male ◯ Female Birth Date _____ Social Security Number _____

Address _____ City _____ Zip _____ State _____

Home Number _____ Work Number _____ Cell Number _____

Marital Status ◯ Single ◯ Married ◯ Divorced Other _____ Referred By _____

Primary Care Physician _____ Drivers License Number _____

Employer _____ Occupation _____ Retired ◯ Yes ◯ No

Preferred Language _____ Race _____ Ethnicity _____

Please bring the following to every appointment:
Current Insurance Card(s), Referral, Picture I.D., List of Medications including Eye Drops

PROTECTED HEALTH INFORMATION
Please checkmark one of the following and list the name(s) and relationship of each person.

☐ Desert Eye Associates, Ltd. may disclose my medical or financial information to the following individuals.

_____ _____

_____ _____

☐ Desert Eye Associates, Ltd. may release my medical or financial information to any person.

☐ Desert Eye Associates, Ltd. **may not** disclose my medical or financial information. The exception to this will be dictated by any Federal or State laws, regulations or statues.

HIPAA INFORMATION:
In signing this form I am giving permission for Desert Eye Associates, Ltd., to speak to anyone answering the above phone numbers or to leave a message on any answering machine. I also acknowledge that I have been presented a copy of the 'Notice of Privacy Practices' for Desert Eye Associates, Ltd. I will inform Desert Eye Associates, Ltd. in writing of any person(s) I do not want my 'Protected Health Information' disclosed to. **This is a lifetime signature unless revoked in writing by patient.**

MEDICARE AND INSURANCE ACKNOWLEDGEMENT:
I request that payment of authorized benefits be made on my behalf to Desert Eye Associates, Ltd. for services furnished by Desert Eye Associates, Ltd. I agree to be responsible for any deductibles, copay, coinsurances, disallowed, and non-covered services not paid for by my insurance carrier(s). Should my insurance carrier change it shall be my responsibility to inform and supply Desert Eye Associates, Ltd., with a copy of my new insurance card(s) and correct billing information before my visit or assume responsibility for charges incurred. I acknowledge there is a $25.00 fee for a personal copy of my chart if I am not releasing it by written consent to another healthcare professional.

CANCELLATION POLICY:
We reserve the right to charge a $50 fee for any appointment not cancelled or rescheduled without providing a 24 hour notice.

SIGNATURE _____ **DATE** _____