

DESERT EYE ASSOCIATES, LTD.
TUCSON AND GREEN VALLEY OFFICES

- Richard P. Marcello, MD
- Jack A. Aaron, MD
- Carmen L. Felix Tacoronte, M.D.
- Karl A. Rosen, M.D.
- James A. Parks, OD

Appointment Date:

Appointment Time:

Last Name First Name Initial

Sex Male Female Birth Date Social Security Number

Address City 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

**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.

<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

- 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 statutes.

HIPPA 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**