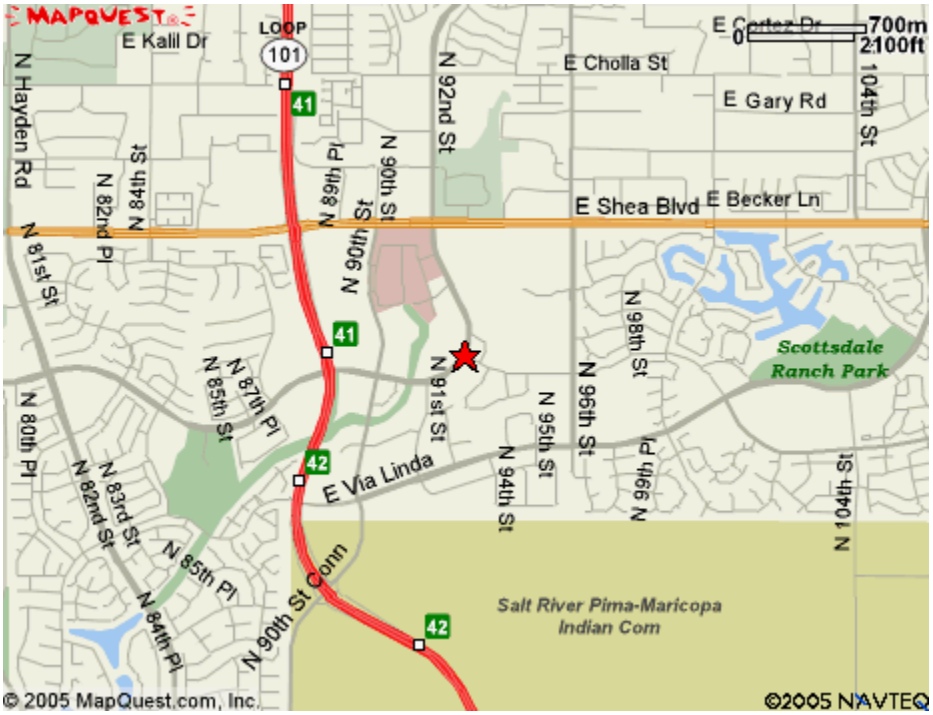
9201 East Mountain View Rd, Suite #125 Scottsdale, AZ 85258
Phone: 480-661-1600 – www.QVisionAZ.com

MAP & DIRECTIONS

- **We are located in North Scottsdale**
- **When taking the Loop 101, exit at Shea Boulevard**
- **Travel East on Shea Blvd ½ mile to 92nd Street**
- **Turn right (South) onto 92nd Street**
- **Travel ½ mile to traffic light**
- **Turn left (East) onto East Mountain View Road**
- **Take the first right into our parking lot**

We are located in the "Computer Associates" building; there are two wings. We are located in the right (north) wing of the building. Our entrance is next to the pedestal sign with our logo. You do not have to go into the main building to access our office.



Patient Information Sheet

NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____

LOCAL ADDRESS:_____ **APT/UNIT#**_____

CITY:_____ **STATE**____ **ZIPCODE**_____ ***SEX:** M F

TELEPHONE NUMBER: (_____)_____ **MARITAL STATUS:** M S W

CELL PHONE NUMBER: (_____)_____ **Email Address**_____

SOCIAL SECURITY:_____ **Do you have a personal/corporate website?**

*www.*_____

RETIRED:_____ OR **EMPLOYER:**_____

ADDRESS:_____

CITY/ST/ZIPCODE:_____

EMPLOYERS PHONE: (_____)_____

NAME OF SPOUSE:_____ **SPOUSES DATE OF BIRTH:**_____
(Needed for Insurance Filing)

INSURANCE INFORMATION: **PRIMARY INSURANCE CO:**_____

SECONDARY/SUPPLEMENTAL:_____

*Patient has HMO coverage and will be SELF PAY *Patient Signature*:_____

*Patient has no medical coverage and will be SELF PAY *Patient Signature*:_____

OUT OF AREA ADDRESS, IF NOT A YEAR ROUND RESIDENT:

ADDRESS:_____ **APT/SPACE#**_____

CITY:_____ **STATE:**_____ **ZIPCODE:**_____

TELEPHONE NUMBER:___(_____)_____ **Dates when in AZ:**_____

EMERGENCY CONTACT: **NAME:**_____

RELATIONSHIP TO PATIENT:_____ **TELEPHONE:**_____

PATIENT'S ARE RESPONSIBLE FOR ALL NON-COVERED SERVICES, ANNUAL INSURANCE DEDUCTIBLES AND ANY COINSURANCES ENFORCED BY THEIR INSURANCE CARRIER. SIGNING THIS ACKNOWLEDGES THAT YOU UNDERSTAND ALL YOUR OBLIGATIONS WITH OUR OFFICE.

REFERRED BY: (PLEASE CHECK)

_____
Patient / Responsible Party Signature

_____

( ) Referring Physician_____
( ) Yellow Pages_____
( ) Patient_____
( ) Other-Please Specify_____

MEDICAL HISTORY

Please be sure to print your name and fill-in the date on the bottom of every page.

Have you AT ANY TIME IN YOUR LIFE experienced the following medical problems?

Irregular heart beat	Y	N	High blood pressure (hypertension)	Y	N
Arthritis	Y	N	Lung disease	Y	N
Cancer	Y	N	Migraine headaches	Y	N
Diabetes	Y	N	Seasonal allergies	Y	N
Heart disease	Y	N	Stroke	Y	N
High cholesterol	Y	N	Thyroid disease	Y	N

Please list any other medical problems (except eye problems which are covered later):

Have you had any of the following surgeries?

Appendectomy	Y	N	Hip	Y	N
Breast	Y	N	Hysterectomy	Y	N
C-Section	Y	N	Knee	Y	N
Gall Bladder	Y	N	Prostate	Y	N
Heart bypass	Y	N	Tonsils	Y	N
Hernia	Y	N			

Please list any other surgeries (except eye surgeries which are covered later):

Do any of the following medical problems RUN IN YOUR FAMILY? Circle unknown if family history unavailable.

Arthritis	Y	N	High blood pressure	Y	N
Cancer	Y	N	Migraine headaches	Y	N
Diabetes	Y	N	Stroke	Y	N
Glaucoma	Y	N	Thyroid problems	Y	N
Heart disease	Y	N	Unknown		

Please list any other medical problems that run in your family:

_____ _____

PRINTED NAME DATE

MEDICAL HISTORY PAGE TWO

Do you have a history of any of the following eye conditions or procedures?

Macular degeneration	Y	N	Conjunctivitis / pink eye	Y	N
Amblyopia / Lazy eye	Y	N	Dry eyes	Y	N
Blepharitis	Y	N	Flashes or floaters	Y	N
Cataracts	Y	N	Glaucoma	Y	N
Cataract surgery	Y	N	Detached retina or hole in retina	Y	N
After cataract surgery YAG laser	Y	N	Surgery for detached retina	Y	N
Chalazion / stye	Y	N	PRK or LASIK	Y	N

Please list any other eye problems or eye surgeries:

Please list any ALLERGIES (MEDICATION OR OTHER) or circle none: None

Please list all of your ORAL MEDICATIONS (or provide a separate list) or circle none: None

Please list all of your EYE DROPS (or provide a separate list) or circle none: None

What is your occupation?

Do you smoke tobacco? If so, how many packs per day?

PRINTED NAME _____ DATE _____

REVIEW OF SYSTEMS

Are you CURRENTLY experiencing or have you RECENTLY experienced any of the following?

Chronic fever	Y	N	Skin rash	Y	N
Weight loss/gain	Y	N	Excessive skin dryness	Y	N
Fatigue	Y	N	Scalp tenderness	Y	N
Difficulty hearing	Y	N	Headache	Y	N
Sinus congestion	Y	N	Numbness	Y	N
Runny nose	Y	N	Weakness	Y	N
Dry mouth	Y	N	Tingling	Y	N
Chest pain	Y	N	Dizziness	Y	N
Irregular hear beat	Y	N	Depression	Y	N
Shortness of breath	Y	N	Anxiety	Y	N
Wheezing	Y	N	Heat intolerance	Y	N
Coughing	Y	N	Cold intolerance	Y	N
Heart burn	Y	N	Excessive thirst	Y	N
Abdominal pain	Y	N	Excessive urination	Y	N
Diarrhea	Y	N	Easy bruising	Y	N
Nausea	Y	N	Excessive bleeding	Y	N
Vomiting	Y	N	Nasal allergies	Y	N
Pain on urination	Y	N	Hives	Y	N
Difficulty urinating	Y	N			
Muscle aches	Y	N			
Joint pain	Y	N			
Swollen joints	Y	N			
Jaw pain	Y	N			

Other than any eye problems you are having, do you CURRENTLY or have you RECENTLY felt ill or unwell in any other way than those listed above? If so, please describe below:

_____ _____

Patient Name (print) Date

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Does the patient have coverage through the VA, the Dept. of Labor's Black Lung Program or any other federal or state agency?	Y	N
Is this illness or injury due to any kind of accident or occurrence?	Y	N
Is the patient 65 or above and employed at the time of this service?	Y	N
Does the patient have a spouse who is employed at the time of this service?	Y	N
Is the patient under the age of 65 and entitled to Medicare solely because of End Stage Renal Disease (ESRD)?	Y	N
Is the patient under the age of 65 and entitled to Medicare solely (unrelated to ESRD) because of disability?	Y	N

_____ _____

Date Signature of Patient (or Responsible Party)

9201 E. Mountain View Rd. #125 Scottsdale, AZ 85258
480-661-1600

Permission Given

I, _____, give permission for the office of Dr. T. Qamar to discuss medical visits, results, etc. with the following members of my family:

_____

_____

_____

_____

_____

_____ _____

DATE SIGNATURE

_____

WITNESS

STATEMENT OF FINANCIAL RESPONSIBILITY

PRINT PATIENT NAME _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to Q Vision for any services furnished to me by the physicians. I authorize the physician to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me, during the period of such medical services, to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

_____ _____

Date Signature of Patient (or Responsible Party)

PAYMENT

I hereby assume responsibility to pay the costs of all services provided by Q Vision and its physicians to the patient.

_____ _____

Date Signature of Patient (or Responsible Party)

AUTHORIZATION OF PAYMENTS

I understand that Q Vision will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Q Vision and its physicians of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and uncovered services.

_____ _____

Date Signature of Patient (or Responsible Party)

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Q Vision for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Date Signature of Patient (or Responsible Party)

MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Q Vision for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

_____ _____

Date Signature of Patient (or Responsible Party)

_____

Medigap Policy Number

HIPAA 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.

This Notice of Privacy Practices describes how we use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support, the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of patient: _____ **Date:** _____