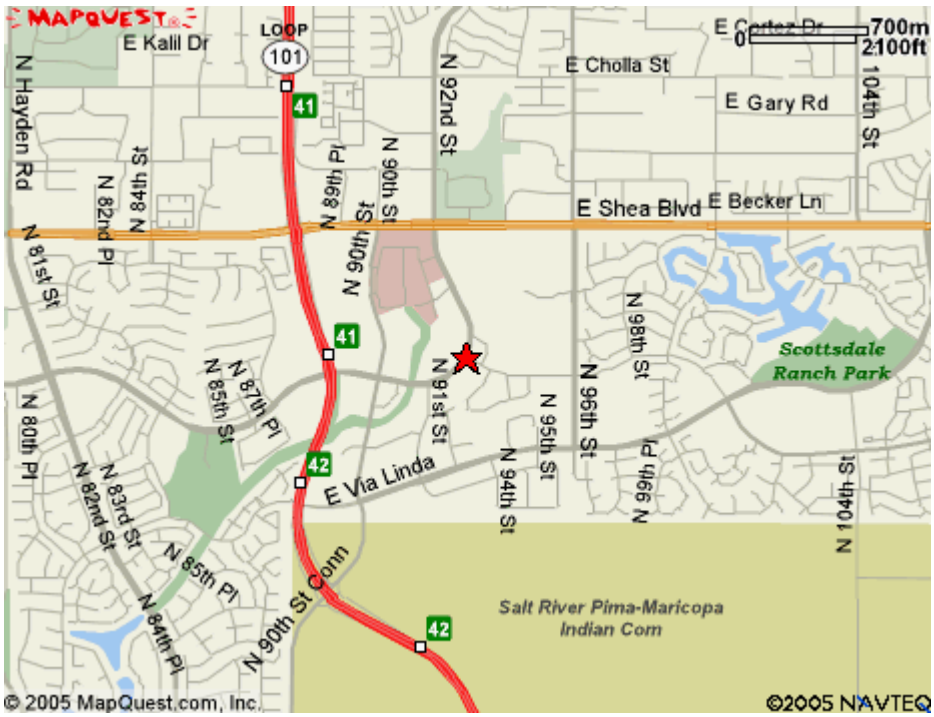
9201 East Mountain View Rd, Suite #125  Scottsdale, AZ  85258
Phone:  480-661-1600  –  www.QVisionAZ.com

## 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.**




0805map.do

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***PATIENT MEDICAL HISTORY***

Name: _____DOB: _____ Age: _____Today's Date: _____

1. Please list any medication allergies you have or circle none: _____ none

2. Do you take any of the following medications? (Check all that apply.)

____ Accutane / isotretinoin (acne)
____ Imitrex / sumatriptan (or similar migraine headache medication)
____ Cordarone / amiodarone (heart)
**____ None of the above**

3. Please list any other medications you take or circle none: _____ none

4. Do you have a history of any of the following eye disorders? (Check all that apply.)

____ Corneal trauma, scar, surgery, disease or disorder
____ Herpes keratitis
____ Keratoconus
____ Cataract
____ Retinal detachment
____ Glaucoma
____ Amblyopia / lazy eye
____ Strabismus / squint
____ Dry eye
**____ None of the above** Other: _____

5. Does anyone in your family have keratoconus? No Yes

6. If applicable, are you currently pregnant, planning on becoming pregnant or nursing?

____ Yes, pregnant
____ Yes, nursing
____ Yes, planning on becoming pregnant
**____ No / not applicable**

7. Do you have a history of any of the following medical problems? (Check all that apply.)

____ Seizures
____ Pacemaker
____ Diabetes
____ Arthritis
____ Thyroid disorder
____ Lupus
____ Scleroderma
____ Dermatomyositis
**____ None of the above**

8. Please describe any other problems or medical conditions here:

Signature: _____

**LASER VISION CORRECTION PATIENT INFORMATION**

Patient Name: (Last)_____(First)_____(MI)_____

Birth Date:_____ Age:_____ Male / Female

Home Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

Occupation:_____Employer:_____

Summer Address:_(if applicable)_____

City:_____State:_____Zip:_____

Summer Phone:_____Summer Work:_____

E-mail Address:_____

Who should we contact in case of emergency?_____

Their phone number:_____Their relationship to you:_____

Who is your family physician:_____Phone:_____

# 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:** _____