

Medical History Questionnaire

Patient Name: _____ Date: _____

Do you presently have any problems in the following areas? Please mark YES or NO on all questions.

Eye History	Yes	No
Loss of vision, blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Loss of side vision		
Double vision		
Dryness		
Mucous discharge		
Redness, sandy, gritty feeling		
Itching, burning		
Foreign body sensation		
Excess tearing/watering		
Glare/light sensitivity		
Eye pain/soreness		
Infection of eye or lid		
Tired eyes		
Crossed eyes, lazy eye		
Drooping eyelid		

Social History	Yes	No
Do you have visual difficulty driving during the day?		
Do you have visual difficulty driving at night?		
Do you currently wear contact lenses?*		
Have you ever tried wearing contact lenses?*		
Do you currently wear glasses?*		
Do you smoke Cigarettes?		
Do you drink alcohol?		

*If you answered YES to wearing contact lenses or glasses, how long have you been wearing your most recent prescription? _____

List any surgeries (including eye surgeries) you have had:

General/Constitutional	Yes	No
Fever		
Weight loss		
Allergic/Immunologic		
Chronic cough		
Dry throat/mouth		
Cardiovascular		
Respiratory problems		
Chronic bronchitis		
Gastrointestinal		
Genitourinary		
Genitalia, Kidney, Bladder		
Muscle, Joint, Swelling		
Neurological		
Psychiatric		
Endocrine		
Hematological/Lymphatic		
Blood		
Lymph nodes		

Are there any other health problems/history we should know about? _____

Please list any known drug allergies:

Are you allergic to latex, tape, or iodine? (If yes, please circle) List any other: _____

Please list any medications currently being used:

Have you ever taken any of the following medications: (if yes, please circle). **Flomax, Hytrin, Cardura, Uroxatral Detrol, Rapaflo, and Tamsulosin.**

Pharmacy Information

Pharmacy name: _____

Pharmacy #: _____

Reviewed By	Date

Allen B. Yeroushalmi, MD
Advance Beneficiary Notice
Refraction Billing Policy

A refraction is performed to measure the strength of your prescription for glasses. A refraction is also an important tool that aids in the diagnosis and treatment of many eye conditions (e.g. cataracts).

However, **Medicare and many other medical insurance plans consider a refraction a “Non-Covered” Service** and require that patients be responsible for payment.

The fee for a refraction is \$75.00 and is to be paid on the day of service. This is in addition to any copay, deductible, or other non-covered service fee.

Patient Waiver and Authorization

I understand that a refraction is a Non Covered Service and agree to comply with the above policy. If I choose to have a refraction performed, I accept full responsibility for the cost of this service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee

Patient Signature

Date



Allen B. Yeroushalmi, M.D.
Board Certified Ophthalmologist

9001 Wilshire Blvd
Suite 306
Beverly Hills, CA 90211

20929 Ventura Blvd
Suite 23
Woodland Hills, CA 91364

(424) 666-1597

Cancellation Policy/No Show Policy for Doctor Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment no show/cancellation policy. The policy enables us to do better utilize available appointments for our patients in need of medical care.

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

A "no show" is someone who misses an appointment without canceling it within a 24 hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

2. How To Cancel Your Appointment

If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel an appointment, please call our office.

3. Cancellation and No Show Fees

Same Day Appointment Cancellation and No Show fee: **\$75.00**

PRINT PATIENT NAME

SIGNATURE/PARENT/GUARDIAN

DATE

Allen B Yeroushalmi, M.D., P.C.

NOTICE OF PRIVACY PRACTICES

Effective Date: 11/1/2017

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 are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly provide health care services with our medical practice. A copy of our current notice will always be posted in our reception area.

If you have any questions about this notice or would like further information, please contact us at 424-666-1597

WHO WILL FOLLOW THIS NOTICE?

Dr Allen B. Yeroushalmi along with employees and associates of Allen B Yeroushalmi, MD, PC.

IMPORTANT SUMMARY INFORMATION

Requirement For Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside the practice. You may also initiate the transfer of your records to yourself or another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write us at Allen B Yeroushalmi, MD, PC. 20058 Ventura Blvd, Suite #139, Woodland Hills, CA 91364.

Exceptions To Written Authorization Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

Exception For Treatment, Payment, And Business Operations. We may use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations. For more information, see pages 4-5 of this notice.

Exception And Disclosure To Family And Friends Involved In Your Care. If necessary, we may include information about you or share your health information with family and friends involved in your care. Although we are not required to obtain your written authorization, we will ask you whether you have any objection to the use or disclosure of your health information in this way. For more information, see page 6 of this notice.

Exception For Public Need. We may use or disclose your health information in certain situations to comply with the law or to meet important public needs. For example, we may share your information with public health officials at the California State or city health departments who are authorized to investigate and control the spread of diseases.

Exception If Information Is Completely Or Partially De-Identified. We may use or disclose your health information if we have removed any information that might identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive the information agrees in writing to protect the privacy of the information. For more information, please see page 9 of this notice.

How To Access Your Health Information. You generally have the right to inspect and copy your health information. For more information, please see page 8 of this notice.

How To Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

How To Identify Others Who Have Received Your Health Information. You have the right to receive an "accounting of disclosures," which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this [Notice of Privacy Practices](#). Many routine disclosures we make will not be included in this accounting, but the accounting will identify non-routine disclosures of your information. For more information, please see page 9 of this notice.

How To Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

How To Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. For more information, please see page 10 of this notice.

How Someone May Act On Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

How To Obtain A Copy Of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. You may also obtain a copy of this notice by requesting a copy at your next visit.

How To Obtain A Copy Of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in our reception area. You will also be able to obtain your own copy of the revised notice by calling our office at 424-666-1597 or asking for one at the time of your next visit. The effective date of the notice will always be noted in the top left corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

How To File A Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact us at 20058 Ventura Blvd, Suite #139, Woodland Hills, CA 91364. *No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient at the practice or receiving treatment or other health-related services from our physicians or other practitioners;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For your information, we have included below a more detailed explanation of how we may use and disclose your health information without your written authorization.

1. Treatment, Payment And Business Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payer. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. We may share your health information with doctors or nurses in our practice or at the hospitals who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor may share your health information with another doctor inside our practice or at the hospital, or with a doctor at another hospital, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to the hospital for a particular type of surgery. Finally, we may share your information with other health care providers and payers for their payment activities.

Business Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and payers for certain of their business operations if the information is related to a relationship the provider or payer currently has or previously had with you, and if the provider or payer is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm, law firm or risk management organization that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

2. Patient Family and Friends

We may use your health information and disclose it, or share it, with family and friends involved in your care. We will always give you an opportunity to object unless there is insufficient time because of a medical emergency (in which case we will discuss your preferences with you as soon as the emergency is over). We will follow your wishes unless we are required by law to do otherwise.

Family and Friends Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or

payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Public Need

We may use your health information, and share it with others, to comply with the law or to meet important public needs that are described below.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;

- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates And Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners And Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4. Completely De-identified Or Partially De-identified Information.

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, web site address, or license number).

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the physician that has your records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you. We may elect to waive this charge.

We will respond to your request for inspection of records within 10 days. If we need additional time to respond to a request for copies, we will notify you within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to the physician where your records are maintained. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right To An Accounting Of Disclosures

You have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared within and between the hospital and the facilities listed at the beginning of this notice, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care; Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);

- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers;

To request an accounting of disclosures, please write to the physician office where your records are maintained. Your request must state a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions please write to the physician who is caring for you. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

Please be aware that we are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to your treating physician's office. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how or where you wish to be contacted.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy practices from Allen B. Yeroushalmi, M.D., P.C.

Signature _____
 Date _____
 Name of Patient _____