Jesse Dominguez O.D.
Jacob Bromley O.D.

725 E. Main St. Suite 1C
Somerton, Arizona 85350
PH: (928) 627-4525
Fax: (928) 627-4524

NEW PATIENT INFORMATION effective 07/11/2023 DATE: ____________

First Name__________________ Last Name_________________ Middle _______________
Birth date ____________ Sex: ( ) Male ( ) Female Social Security No. _________________
Mailing Address______________________________P.O. Box________________________
City ________________________________ State ______________ Zip ______________
Home Phone:________________ Cell:_______________ EMAIL:_____________________

OCULAR HISTORY

Date of last exam ___________________ Name of Doctor ________________________
Do you wear glasses ( ) Yes ( ) No If yes, ( ) all the time ( ) occasionally ( ) reading ( ) driving
Do you wear contacts ( ) Yes ( ) No / ( ) Soft ( ) Hard, Brand:____________________
Whom may we thank for referring you to this office? _____________________________
Please list any **medication** you are taking____
____
Please list any **eye drops**____
Please list any medications you are **allergic** to _______________________________________
Are you pregnant or nursing? ( ) Yes ( ) No
Do you smoke? ( ) Yes ( ) No Do you drink Alcohol? ( ) Yes ( ) No
Additional Comments: Is there anything else we should know about?
____

Do you have or have you had any of the following within the past year?
(Check any that apply)

___ Eye injury R/ L
___ Eye Surgery R/ L
___ Eye infections R/L
___ Sticky discharge R/L
___ Itchy eyes R/L
___ Burning eyes R/L
___ Double vision
___ Watery eyes R/L
___ Red eyes R/L
___ Pain in eye R/L
___ Frequent headaches
___ Blurry vision
___ Glaucoma
___ Diabetes
___ Cataracts R/L
___ Floaters R/L
___ High Blood Pressure

INSURANCE INFORMATION (MEMBER)

Primary insurance:

Name of Insured ____________________________ Insured's Date of Birth______________
Insured's Social Security # ____________________ Policy/ ID # _____________________
Insured's Employer ____________________ Insurance Company _____________________

Secondary/ Supplemental insurance:

Name of Insured____________________________ Insured's Date of Birth______________
Insured's Social Security # ____________________ Policy/ ID # _____________________
Insured's Employer ____________________ Insurance Company _____________________

Cancellation Policy: We require 24 hour advance notice of cancellation. If you are unable to make your appointment, please call the office so other patients who are in need of treatment can be scheduled accordingly.

Missed Appointments: Patients who do not show up for their scheduled appointment without a 24 hour advanced notification will be considered missed/failed appointments and will have a charge of $30.00. This is not covered by your insurance. After 3 missed appointments, may result in dismissal from our practice.

Tardiness: Patients who are more than 15 minutes late for their treatment appointment may not be seen and may be rescheduled, unless you have called our office letting us know about your delay then you can be seen depending if the office has a no show appointment.

Appointments for Treatment: Please be advised that only one parent/guardian will be allowed in the treatment room due to limited space. Please make arrangements for your other children, as they will not be allowed in the treatment room unless they are being seen.

Family Member Appointments: Only two (2) members of a family may be scheduled on the same day for treatment. We apologize for any inconvenience this may cause.

Cell Phone usage in the office and in exam/treatment rooms: Please be advised that the use of your personal cell phone in the exam and treatment rooms is strictly prohibited. Recording or taking pictures during a visit with any type of device is also prohibited.

Collection Accounts/Accounts with balance:

When an account remains unpaid for 90 days, we reserve the right to reschedule or deny future appointment for delinquent accounts. If your account is sent to a collection agency you may be asked to find a new provider.

Authorization to Release Information:

On April 14, 2003 a new Federal Law, HIPAA, went into effect to protect your personal health information (PHI) . If you need to authorize someone else to have access to your records in our office please list them and their relationship to you below. Please note, that under this new law we cannot release information to a spouse or a parent if the minor is 18 or older, regardless of who is responsible for the charges.

Name:__________________________ DOB____________________Relationship__________________

Name:__________________________ DOB____________________Relationship__________________

Insurance Agreement and Release:

I, the undersigned, certify that I or my dependent have insurance coverage with the above Insurance Company and assign directly to Somerton Eyecare Center, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: ____ **Date:** _______________________

If patient is a **minor**, Responsible Party Signature: ____

Print Name: __________________________ Relationship: __________________ Date of Birth:_________

Insurance Policy:

Insurance co-payments and/ or deductible amounts are due at the time services are rendered.

Any balances not paid by the insurance company will be billed to the patient. Payment is expected upon receipt of the statement.

We will gladly bill your insurance on your behalf, however we cannot guarantee payment of your claim. If we are unable to collect payment from your insurance company or they deny your coverage you will be responsible for the balance.

18 Years of age and over financial agreement and consent.

Though you may still be covered under your parent's insurance, you, as an adult, are solely financially responsible for any and all payments: copay, coinsurance or deductible that your insurance deems as your responsibility.

Fees

Comprehensive Vision Examination:	$144- $169 ($99 cash discount)
Contact Lens Examination, Starting at:	$149- $189 (excluding specialty contacts)
Medical office visit for eye injury - minimum:	$54 average $87
Medical Fundus photography:	$92.68 ($55 cash discount)
OCT, scanning computerized Ophth imaging:	$55.04 ($44 cash discount)
Refraction only:	$30

Please check the method of today's payment ( ) cash ( ) check ( ) debit/credit or ( ) Care Credit.

Financial Policy:

In the event that I/we have failed to pay for services provided by this office, and the account is placed for collection, I/we understand and agree that an additional amount equal to 40 % of the balance owed at the time the account is placed for collection, will be added to the current balance owed, I/we agree to pay interest at the rate (10%) ten percent per annum until the amount owed is paid in full. I/we further agree to pay all attorneys fee and court cost, necessary to collect this balance. Non sufficient checks will be charged an additional $35 fee.

I agree to pay any collection fees and all other costs that may incur to enforce collection of any amount outstanding.

I acknowledge that I have read, understand, and am willing to comply with the above guidelines and finance responsibility.

Patient Name:______________________Patient Signature: ___________________Date: ___________

If patient is a **minor**, Responsible Party Signature: ____

Print Name: _________________________ Relationship: __________________ Date of Birth:_________

THANK YOU for trusting us here at Somerton Eyecare Center, Inc. with your vision needs.

Somerton Eyecare Center
Dr. Jesse V. Dominguez O.D.
725 E. Main St. Suite 1C
Somerton, Az. 85350
928-627-4525

EFFECTIVE DATE: 04/08/2019

Frame and Lens Warranty
We guarantee 100% accuracy on all prescriptions or they will be remade at no charge.
Fitting and adjustment repairs that do not require parts to be purchased will be done free of charge.

Your new glasses are warranted against manufacturer's defects, which includes material and workmanship, for one year from the date-of-purchase.

LENSES: Under normal use if the lenses are scratched, they may be replaced once per year at no fee.

This does not pertain to lenses damaged outside of normal use, i.e. the dog chewed them, they are scraped from being stepped on, usage of glue etc. It is the sole discretion of Somerton Eyecare Center to determine if the lens warranty applies.

- **A.R. Coatings** are eligible for one time replacement within 12 months from purchase date.

- **Non Adapt to Progressive**: In the event that you are unable to adapt to your progressive lenses, you will be permitted to switch to a lined bifocal or single vision lens for no additional charge within 90 days of your purchase date. No monies will be refunded or returned. After 90 days the patient will be charged in full.

PRESCRIPTION OR LENS CHANGES: We will replace any prescription lens due to prescription change at no charge within 90 days of exam if the replacement cost is equal or less than the original. A request for a more expensive product will require a charge for the difference in price. Any change after 90 days or any subsequent changes for the same patient will be charged at 100%.

FRAMES: Have warranty for a 1 year period against manufacturer defect under normal use and service and will be replaced for a $25.00 fee for shipping and handling. **Do not use GLUE, it voids warranty. Breakage by misuse, abuse or loss is not covered by warranty. It is at the sole discretion of Somerton Eyecare Center to determine whether the warranty applies.**

F**RAME RESTYLE:** We are glad to remake your lenses into another frame if the one chosen does not work out for you, within 30 days of pickup for a fee of $25. Frames must be returned in perfect condition for full credit of exchange. May receive up to 50% credit if not in perfect condition. (Exclusions may apply for Tiffanys, Dolce and Gabanna etc.) You can exchange it for an equal or lesser value. You will be charged the difference if the new frame exceeds the original price. There will be no credits or refunds for products of lesser value. Prescription lenses are specific to each individual and cannot be re used once they are changed into another frame.

PATIENTS OWN FRAME: Please be advised that older frames can lose their original shape and durability, putting new lenses on older frames may cause for lenses to come out of the frames or to break during the process. Please Note: Somerton Eyecare Center is not responsible for damage or breakage to customer's own frame, new or used, if only prescription lenses are ordered. Due to these reasons, we prefer not to use

a patients own frame. We may make an exception if no other means are available to purchase a new frame. We are happy to give a discount on the purchase of a new frame so that it will be under warranty.

Cancellations: Glasses are custom ordered and therefore we require a half down deposit when you place your order, and full payment is due at pickup. Canceled orders are subject to a 50% cancellation fee and deposits will not be returned once the job is in process. Designer frames cannot be returned and are non-refundable purchases.

Contacts: Within 30 days of your order only unopened and unmarked contact lens vials or boxes may be returned or exchanged. A restocking fee will apply to all unopened contact lens vials or boxes returned for credit. No credits or exchanges are permitted on opened boxes or vials.
Please note: Contact Lenses services are not refundable. It is your sole responsibility to schedule and show up for your contact lenses follow up appointment. This will ensure proper prescription and fit of your contact lenses.

*** Should you need a frame and/or lens replacement that is not covered under the manufacturer's warranty, Somerton Eyecare Center will extend a 50% discount off the retail price to replace a frame, and 20% discount off the retail price to replace lenses, if exam prescription is still current.**

Patient/ Guardian Signature: ________________________________ Date____________________

Print name:____

If minor, relationship to patient:____

SOMERTON EYECARE CENTER

OPTOMETRIST: Dr. Jesse V. Dominguez

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be

made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
- was not created by us, unless the person that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for us,
- is not part of the information you would be permitted to inspect or copy, or
- is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Somerton Eyecare Center
Nancy De La Vara
725 E. Main Street Suite 1C
PO Box 634
Somerton, Az. 85350
928-627-4525
nancy@somertoneyecare.com

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: Sept. 1, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Somerton Eyecare Center's Notice of Privacy Practices.

Date: ___________

Patient name:_______________________________

Signature: ____________________________________

Relationship to Patient if minor:

____