Efraim Duzman, M.D.
Eran Duzman, M.D.
A PROFESSIONAL CORPORATION
EYE PHYSICIANS AND SURGEONS

To all patients,

We welcome you to our office, and thank you for entrusting us with your eye care. Below is a list of our office policies and procedures, as well as our commitment to you, our patient. If you have any further questions or concerns, please call the office and ask for the Manager.

1. Please provide accurate and complete health and history information to our physicians, so we may provide the best possible care to you. It is extremely important to build open, honest communication with your physician.
2. Please provide your most current insurance information, so we may bill correctly and in a timely manner. It is your responsibility to know your plan details. Contact your heath plan if you have any questions. Note: All co-payments and co-insurance are due at the time of service. We also have a $25 returned check fee.
3. Please keep all scheduled appointments, or give adequate notice for delay or cancellation. We charge a $40 "No-Show" fee for missed office visits, and a $100 "No-Show" fee for missed surgical visits.
4. Please keep consistent and open communication with your Primary Care Physician. We are happy to send correspondence regarding your care with us as well.
5. We are happy to send your medical records to another office free of charge, however, if you request a secondary copy for personal use, we charge a minimum of $25 dollars.
6. We ask that you treat all providers, office personnel, and other patients respectfully and courteously. Our staff is committed to the same for you.
7. If you need information, or are inquiring about *Advanced Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will)*, please call the Member services department of your health plan or the patient relations department at Hoag Hospital.
8. Please keep your pharmacy information up to date. We send electronic prescriptions from our office automatically to the pharmacy you have on file.
9. DILATION: You may be dilated in our office. Dilating drops are instilled to enlarge the pupils of the eye, so the doctor has a full view of the back of the eye and the retina. Dilating drops may blur your vision for a few hours, and can vary from patient to patient on the degree of light sensitivity created. Driving may be impaired for some, so it is always recommended to have someone drive you until you are certain of your response to the drops. One adverse, although extremely rare reaction to dilation, can be acute angle-closure glaucoma. If this happens, it can be treated immediately in the office with our physician. You may decline dilation at any time, with the understanding that your exam may be limited by this decision.
10. We are committed to our patients health and well-being. We are always available for urgent, or emergent appointments. We give all patients the time needed to address each individual concern, as such, some wait times may be longer than usual. We promise that when your appointment time arrives, you will be afforded the time and attention that you need and deserve.

I have reviewed the policies and my responsibilities, and I agree to accept them:

_____Print Name
_____Signature _____ Date pg 6

LAKESIDE VISION CENTER

Patient Consent for Use of Email Communication

To better serve our patients, our office has established a patient portal as a form of communication. The patient portal offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. For routine matters that do not require immediate response, please feel free to contact us through the patient portal. The turnaround time for routine patient communication is within 24 hours. **Please remember however, that this form of communication is not appropriate for use in an emergency. Should you require urgent or immediate attention, please contact the office directly.**

By using our patient portal system, you will be able to go online and do the following:

- Request medication refills
- Review your medical summary, medication list, treatment history, and appointment history
- Request an appointment and appointment changes
- Communicate with office staff and physicians via secure messaging
- Allow designated family members to access your information with your consent

Responsibilities of Patient Portal Users

Every authorized portal user has responsibility to protect the confidentiality of health records. All authorized portal users expected to keep their portal user ID and password secure to prevent any unauthorized access to patient information. LAKESIDE VISION CENTER is not liable for breaches of confidentiality arising from unauthorized use of such information. If you suspect that someone has learned your password, you should access the portal site immediately and change it. If you become aware of a breach, for whatever reason, of this confidentiality, you are expected to promptly report it to Lakeside Vision Center.

Consent

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications.

Date: _____

Patient Name: _____ Patient Signature: _____

Email Address: _____

Patient Representative (if applicable): _____

Name:
DOB:

Date:

LAKESIDE VISION CENTER

DR. EFRAIM DUZMAN, MD
DR. ERAN DUZMAN, MD
DR. MILA KAMENEV, OD

4605 BARRANCA PARKWAY #100
IRVINE, CA 92604
(949) 733-2002 FAX (949) 733-1854

Rx History Consent

I authorize LAKESIDE VISION CENTER to access my prescription medical history from other healthcare providers or third party pharmacy benefit payers in order to reconcile all medications with the purpose of improving patient care, patient safety, and clinic efficiency.

I authorize LAKESIDE VISION CENTER to obtain my medical prescription history for the duration of two years from the date undersigned.

Patient Name _____ Patient Signature _____ Date _____

Patient Preferred Pharmacy

Complete pharmacy information below to indicate which pharmacy your electronic prescriptions will be sent.

Preferred Pharmacy Name _____ Preferred Pharmacy Phone Number _____

Preferred Pharmacy Address _____

Name:
DOB:

Date:

PATIENT MEDICAL HISTORY QUESTIONNAIRE

LAKESIDE VISION CENTER

PLEASE SELECT YES NO

Cardiovascular

☐Y ☐N High Cholesterol
☐Y ☐N Heart Attack
Date:_____
☐Y ☐N Angina
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Artificial Heart Valve
☐Y ☐N Stroke
Date:_____
☐Y ☐N High Blood Pressure
Date:_____
☐Y ☐N Pacemaker

Respiratory

☐Y ☐N Asthma
☐Y ☐N COPD/Emphysema
Other_____

Endocrine

☐Y ☐N Diabetes Type 1 or Type 2
Insulin or Non-Insulin
Date:_____

☐Y ☐N Thyroid

Glasses or Contact Lenses? _____

Past Medical History/Review of Systems:

Skin Problems

☐Y ☐N Acne
☐Y ☐N Skin Cancer

Ear/Nose/Throat

☐Y ☐N Sinus Problems
☐Y ☐N Hearing Aids

Hematologic

☐Y ☐N Anemia
☐Y ☐N Bleed/bruise easily
☐Y ☐N Cancer
Type:_____

Ocular History

☐Y ☐N Cataract
☐Y ☐N Glaucoma
☐Y ☐N Retinal Tear/Detachment
Other:_____

Gastrointestinal

☐Y ☐N Ulcers
☐Y ☐N Colitis
☐Y ☐N Diverticulitis
☐Y ☐N Liver/hepatitis

Genitourinary

☐Y ☐N Kidney
☐Y ☐N Bladder
☐Y ☐N Prostate

Musculoskeletal

☐Y ☐N Arthritis
☐Y ☐N Joint Replacement
Date:_____

Neurologic/Psychiatric

☐Y ☐N Seizures
☐Y ☐N Parkinson's Disease
☐Y ☐N Alzheimer's
☐Y ☐N Anxiety/Depression
☐Y ☐N Multiple Sclerosis/MS

Surgical history/including **eye surgery**)

_____

_____

Please list **all medications** you are currently taking:

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

Please list any **allergies** to medicines:

_____

Social History: Smoking ☐Y ☐N (If YES: packs per day_____) (If Quit Smoking: Date:_____)
Alcohol ☐Y ☐N (If YES: occasional / 1 per day / 1 per week / Other_____)

Family History:

☐Y ☐N Cancer
☐Y ☐N Heart Disease
☐Y ☐N Macular Degeneration

☐Y ☐N Diabetes
☐Y ☐N Glaucoma

☐Y ☐N Hypertension
☐Y ☐N Retinal Detachment
☐Y ☐N Other_____

_____ Technician

_____ M.D. Signature

Name:
DOB:

Date:

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of said notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Representative: _____

Signature: _____ Date: _____

PLEASE LIST ANY FAMILY MEMBERS WE CAN RELEASE YOUR MEDICAL INFORMATION TO BELOW.

X _____

I attempted to obtain the signature of the patient or patient's representative acknowledging receipt of the "Notice of Privacy Practices" for **DR. EFRAIM DUZMAN MD, INC.**, but was unable to do so, as documented below:

Date	Reason	Name	Signature

Name:
DOB:

Date:

NEW PATIENT DEMOGRAPHIC INFORMATION
LAKESIDE VISION CENTER

PATIENT INFORMATION — PLEASE COMPLETE ALL BLANKS						
				DATE	REFERRED BY (NAME OF PHYSICIAN OR REFERRING PARTY)	
NAME - LAST			FIRST			MIDDLE INITIAL
ADDRESS-STREET				CITY		
STATE	ZIP	(AREA CODE) HOME PHONE NUMBER	(AREA CODE) CELL PHONE NUMBER	DATE OF BIRTH	AGE	
SOCIAL SECURITY NUMBER		SEX	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED		SPOUSE'S NAME	
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE NUMBER	Preferred Language (Please Circle) English Spanish Chinese Japanese Vietnamese Arabic Farsi Other		Smoking Status Former Current Never	
EMPLOYER		WORK STATUS	JOB DESCRIPTION		(AREA CODE)TELEPHONE NUMBER	
INSURANCE NAME			INSURANCE ID#			
RESPONSIBLE PARTY						
☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER _____						
NAME (LAST, FIRST, MIDDLE INITIAL)		(AREA CODE) TELEPHONE NUMBER		SOCIAL SECURITY NUMBER	DATE OF BIRTH	
ADDRESS (IF DIFFERENT THAN ABOVE) (STREET, CITY, STATE AND ZIP CODE)						
EMPLOYER				(AREA CODE) TELEPHONE NUMBER		
PRIMARY CARE PHYSICIAN			OTHER TREATING PHYSICIAN			
PHYSICIAN NAME			NAME			
(AREA CODE) TELEPHONE NUMBER			(AREA CODE) TELEPHONE NUMBER			

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Lakeside Vision Center. I understand that I am financially responsible for any unpaid balances. I also authorize Lakeside Vision Center to release to my insurance carriers any information required to process this claim

SIGNATURE

Dr. Efraim Duzman, MD Dr. Eran Duzman, MD Dr. Mila Kamenev, OD

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