CONSENT FORM

Laser Optic and Aesthetic Center
John G. Rezapour, M.D., Inc.
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Encino, CA 91316
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I. I have seen the announced fees for my medical services, and all my options have been explained to me. I hereby authorize my insurance Company to pay directly to LaserOptic and Aesthetic Center. I understand if my insurance Company fails to pay, I am one hundred percent responsible to pay the full amount, or any balance. **Initials:**_____

II. I have read the Notice of Privacy Practices mandated by HIPPA. All my questions have been answered by the staff of the practice, and I am clear about the privacy policy of LaserOptic and Aesthetic Center. I have received a copy of "Notice of Privacy Practices" from LaserOptic and Aesthetic Center.

By signing this form, **I** _____, authorize the use and disclosure of my health information as described below:

A. Description of information: this information may include your personal history, insurance information, and your medical records.

B. Name or class of person(s) or class of persons authorized to male the use of disclosure: John G. Rezapour M.D.

C. Name or identification of person(s) or class of persons authorized to receive the information :

1. Your insurance company for billing and collection.
2. Your lawyer or any party that you assign.
3. To defendant or legal authority (in Worker's Compensation Cases).
4. Others: _____.

D. Date or event when authorization expires: Unlimited, unless you cancel it in written notice.

E. Description of each purpose of the requested use or disclosure: for billing and collection purposes (only limited necessary information). Upon request of legal authorities or your insurance company. To other medical providers participating in you care. I understand that I have the right to revoke this authorization, in writing, at any time, except:

1. Where uses or disclosures have already been made based upon my original permission.
2. The authorization was obtained as a condition of securing insurance coverage, and the insurer by law has the right to contest a claim or the insurance policy.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to John G Rezapour, M.D. I understand that it is possible that information used to disclose with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards. I understand that LaserOptic and Aesthetic Center may not condition my treatment on my signing this authorization. I have the right to refuse to sign this authorization. **Initials:** _____. I understand that LaserOptic and Aesthetic Center may condition my treatment on my signing this authorization to provide information as requested by the third party indentified in section 2.B of this consent form. If I do not sing the authorization, LaserOptic and Aesthetic Center has the right to refuse to provide such treatment. **Initials:** _____

Signature of Patient or Guardian: _____ **Date:**_____

INFORMATION REGARDING DILATING EYE DROPS:

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye. Dilating drops frequently blur vision for a length of time which from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, its best if you make arrangements not to drive yourself. Adverse reaction, such as acute angel-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Dr. John G. Rezapour and / or such assistants as may be designated by him/ her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Signature of Patient or Guardian: _____ **Date:** _____

Signature of Witness: _____ _____ **Date:** _____