PATIENT INFORMATION: Today's Date_________________________ Acct #________________________

Patient____
Last First Middle
Address____

City and State____ Zip______________

Cell Phone (_____) __________________ Home Phone (_____) _____________ Marital Status_________________

Date of Birth_________________ Age______ ☐ Male ☐ Female Social Security #______________________

Driver's License #________________________________ E-mail Address___________________________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ White

☐ Native Hawaiian/Other Pacific Islander

Can we E-mail information to you periodically? ☐ YES ☐ NO Employer _____________Work Phone ___________

IN CASE OF EMERGENCY: Name ___________________________________Phone #________________

PHARMACY: Name___________________________________ Phone #__________________

RESPONSIBLE PARTY if other than patient:

Name____ Social Security #__________________
Address____ Driver's License #_________________
Employer____ Telephone________________________

ACCIDENT: Industrial/Work Related? ☐ YES ☐ NO Auto Accident? ☐ YES ☐ NO

Did you come through Emergency Room? ☐ YES ☐ NO Other Accident? ☐ YES ________________________

Date of injury___________________ Has employer been notified?________ Has carrier been notified?____________

HOW WERE YOU REFERRED TO THIS OFFICE?

☐ Internet ☐ Friend/Patient ☐ Other (specify)____

Physician/Optometrist: ____
Name Address
Primary Care Physician____ Referring Medical Group_____________

MEDICAL INSURANCE INFORMATION: (Attach copy of cards)

(1) PRIMARY Insurance Co.: _____________________________________ Group/Policy#_________________

Policy Holder____ Member/ID #_________________

Policy Holder Date of Birth______________________________________ Policy Holder ☐ Male ☐ Female

Patient Relationship to Policy Holder____

(2) SECONDARY Insurance Co.:

Insurance Company____ Group/Policy #_________________

Policy Holder____ Member/ID #__________________

Policy Holder Date of Birth______________________________________ Policy Holder ☐ Male ☐ Female

Patient Relationship to Policy Holder____

PACIFIC EYE INSTITUTE

OFFICE USE ONLY
PN: ________________
DOS: ________________

Medical History Questionnaire

Name: ____ **Date of Birth:** ______________________

Vision Correction - Do you wear glasses? ☐ No ☐ Yes Do you wear contact lenses? ☐ No ☐ Yes
Reason(s) for visit – In your own words, please describe the reason for your visit today:
____
____

Visual Function Questions – Please check if you are experiencing difficulty with any of the following:

No	Yes		No	Yes	
		Reading Small Print			Watching Television
		Reading Traffic or Street Signs			Driving at Night
		Driving in Bright Light			Seeing Steps, Curbs or Stairs
		Glare or Halo			Floaters or Flashes
		Dry, Red, Sandy or Itchy Feeling			Other:

Allergies – Please list all known medication (including intravenous contrast dye and anesthetics) and environmental (including seasonal, food and latex) allergies or indicate ☐ NO KNOWN ALLERGIES.

Allergy	Reaction	Allergy	Reaction

Current Medications – Please list all current prescribed medications (including eye drops and medical cannabis), over-the-counter medications, vitamins and supplements or indicate ☐ NO MEDICATIONS.

Name	Dosage	Frequency	Name	Dosage	Frequency

Review of Symptoms – Please check if you are experiencing any of the following:

N	Y	Constitutional	N	Y	Cardiovascular	N	Y	Endocrine	N	Y	Integumentary
		Fatigue			Chest Pain/Pressure			Cold Intolerance			Hives
		Fever			Irregular Heartbeat			Heat Intolerance			Rash

N	Y	HEENT	N	Y	Gastrointestinal	N	Y	Neurological	N	Y	Musculoskeletal
		Bulging Eyes			Abdominal Pain			Imbalance			Back Pain
		Hearing Loss			Constipation/Diarrhea			Headache			Joint Stiffness
		Sinus Problems			Nausea/Vomiting			Memory Difficulty			Muscle Weakness

N	Y	Respiratory	N	Y	Genitourinary	N	Y	Psychiatric	N	Y	Hematologic
		Asthma			Pain with Urination			Depressed Mood			Bleeding
		Cough			Blood in Urine			Irritability			Bruising
		Wheezing									Tender Lymph Nodes

Current Height: ______________________________ **Current Weight:** ______________________________

PACIFIC EYE INSTITUTE

Past Ocular and Surgical History – Please check if you have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type):

No	Yes		No	Yes	
		Cataract:			Cornea:
		Glaucoma:			LASIK:
		Oculoplastic:			Retina:
		Other:			Other:

Personal and Family Health History – Please check if you or a family member have / have had any of the following or indicate ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY.

	Self	Mother	Father	Sister	Brother
Allergies					
Anxiety					
Auto-Immune Disorder (note type)					
Blindness					
Cancer (note type)					
Cataracts					
Corneal Disease					
Diabetes (note type)					
Depression					
Glaucoma					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Lazy Eye					
Macular Degeneration					
Migraines					
Retinal Disease					
Seizure Disorder					
Stroke					
Thyroid Disorder					
Other:					
Other:					

Females: Are you currently pregnant? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes

Social History

Have you ever used tobacco? ☐ No ☐ Yes - If yes: ☐ Former ☐ Current Every Day ☐ Current Some Day

Tobacco Product: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/chew ☐ Smokeless ☐ Other: ________________

Do you drink alcohol? ☐ No ☐ Yes - If yes: _____ drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Do you drink or consume caffeine? ☐ No ☐ Yes - If yes: ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets

Occupation: ____ Status: ☐ Full Time ☐ Part Time ☐ Retired/Other

FINANCIAL POLICY

Welcome and thank you for choosing us as your eye care provider. We are committed to providing you the finest care and service.

FINANCIAL RESPONSIBILITY: You are responsible for payment of all charges associated with your visit. As a courtesy, and for your convenience, we bill your insurance company when you have provided us with all the requested insurance information. You are responsible for your deductible, co-payment, co-insurance, and non-covered service at the time the services are rendered. If uncertain of your coverage, please contact your insurance company. If you choose not to bill your insurance for care provided, it is understood that you assume financial responsibility for all charges.

METHOD OF PAYMENT: We accept cash, check, Visa, MasterCard, and American Express, Discover, and CareCredit.

PATIENT BILLING: Patients who have outstanding balances are billed monthly. All balances are due within 30 days from the billing date. All outstanding balances must be paid prior to any future services being rendered.

RETURN CHECKS: A $25.00 fee is charged for all returned checks.

I clearly understand and agree to the provisions of this financial policy:

Patient Name: ____

Signature of Responsible Party: ______________________________________

Date: _____________________

*Please present your Driver's license and insurance information to the receptionist.

Signature on File, Assignment of Benefits & Financial Agreement

_______________________________________ _______________________

Beneficiary Name (print) Medicare or Insurance ID

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Pacific Eye Institute, for services furnished me by Pacific Eye Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Pacific Eye Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Pacific Eye Institute, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Pacific Eye Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Pacific Eye Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. Pacific Eye Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Pacific Eye Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Pacific Eye Institute has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Pacific Eye Institute if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Pacific Eye Institute's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Pacific Eye Institute to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Pacific Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Pacific Eye Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Pacific Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Pacific Eye Institute. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

X_______________________________________ ________________

Beneficiary Signature or Authorized Party Date

PACIFIC EYE INSTITUTE

Authorization to Release Information

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. The law does not require Pacific Eye Institute to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment and health care operations. You have the right to revoke this Acknowledgement, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. Pacific Eye Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Authorization: It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, “by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care.”
The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.
☐ *Cell phone:* ________________________________ ☐ *Email address:*___________________________________
☐ *Fax number:* _______________________________ ☐ *Phone:* ____
☐ *US Mail:* ____ *(address)*

Description of information to be disclosed: I authorize the practice to disclose the following PHI about me. (Provide a written description of the information to be disclosed):

____

Expirations or termination of authorization: This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date. (Please list desired expiration date):

____

Protected Health Information (PHI) may also be disclosed to the following person(s):

____

This Acknowledgement was signed by: ____
Signature

Please also print the name of the person signing the form: _____________________________

Relationship to Patient (if other than patient): _____________________________

Date: _____________________________

In front of: ____________________________________
Printed Name – Practice Representative

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.

If you have any questions about this Notice please contact the Privacy Officer, Elvita Grigoryan, Regional Compliance Manager: (909) 982-8846. Effective Date: April 14, 2003; Revised: January 21, 2020.

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.pacificeyelaser.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate

can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You can obtain a request for copies of your protected health information from our Front Desk.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide

you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:
Elvita Grigoryan, Regional Compliance Manager: (909) 982-8846.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

INFORMED CONSENT FOR DILATED EYE EXAMINATION

In the course of your care, whether today or in the future, it is important for your doctor to evaluate your retina, macula and optic nerve with a dilated examination. Dilating eye drops are used to enlarge the pupil of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes (blurs) vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements. The majority of patients do drive after dilation with the assistances of temporary sunglasses, which we will provide after your examination.

Adverse reactions, such as a rises in eye pressures causing pain may be triggered by the dilating drops. It may be necessary to lower the pressure by the use of eye drops, oral medication and/or laser treatment. There is also a possibility of an allergic reaction to the dilating drops.

The decision to undergo dilation is yours. You may choose not to have the dilation performed; however, our doctors recommend that dilation of the pupil be performed to better examine your eyes for disease.

I have read and understand the above information regarding the dilation of my eyes and hereby authorize the doctor and/or technician to administer dilating eye drops.

______________________________ ______________________________

PATIENT NAME DATE

____

SIGNATURE