SOUTHERN CALIFORNIA
EYE CONSULTANTS

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Phone 714-771-2020 Fax 714-771-1900 www.southcaleye.com

Today's Date _____

Referring Physician Dr. _____ Fax:_____

Primary Care Physician Dr. _____ Fax:_____

Eye Doctor Dr. _____ Fax:_____

How did you hear about us?

Physician Our Website Internet Site_____ Friend _____

Advertisement _____

PATIENT INFORMATION

Dr. Mrs. Ms. Mr. First_____ M.I._____ Last_____

Sex: M F SS#_____ Date of Birth_____/_____/_____ Age_____

Marital Status Married Single Partnered Divorced Widowed

Mailing Address_____ Email_____

City_____ State_____ Zip_____

Home # (_____)_____ Cell # (_____)_____

Employer_____ Work # (_____)_____

Emergency Contact: Name_____Phone # (_____)_____Relationship_____

Pharmacy Name /Location_____ Number_____

INSURANCE INFORMATION

If you would like us to file claims with insurance, please fill out the section below. **You may be required to obtain an up to date referral** from your primary care physician before insurance will pay for an exam. While it is the responsibility of the patient to obtain referral authorization before their visit, our office will do everything possible to obtain the referral for you if you have not done so already. Per the contract between you and your insurance company, you will be responsible for any charges if a referral cannot be obtained and your insurance company denies payment.

Primary Insurance_____ HMO_____ PPO_____ Other_____

Subscriber's Name_____ Subscriber's DOB _____/_____/_____

Subscriber's SS#_____

Secondary Insurance_____ HMO_____ PPO_____ Other_____

Subscriber's Name_____ Subscriber's DOB_____/_____/_____

Subscriber's SS#_____

MEDICATIONS _____

_____

_____

_____

ALLERGIES _____

DO YOU WEAR CONTACT LENSES? Y N

HAVE YOU HAD LASIK/PRK/RK? Y N

EYE HEALTH HISTORY (CIRCLE)

BLEPHARITIS	EYE INFECTIONS	**Please List Eye Any Surgery Below:**
CATARACTS	EYE ALLERGY	
CATARACT SURGERY	CROSSED EYES	_____
CONJUNCTIVITIS/PINK EYE	PTOSIS	
DRY EYES	DIABETIC RETINOPATHY	_____
GLAUCOMA	RETINAL DETACHMENT	
GLAUCOMA SURGERY	LASIK/LASER VISION CORRECTION	_____
LAZY EYE/AMBLYOPIA	VISION LOSS	
DIPLOPIA/DOUBLE VISION	TEMPORAL ARTERITIS	_____

MEDICAL HISTORY (CIRCLE)

AIDS/HIV	KIDNEY DISEASE	Do you smoke? Y N
ARTHRITIS	LUPUS	Do you drink? Y N
ARTIFICIAL VALVE	MIGRAINES	Do you use drugs? Y N
ARTIFICIAL JOINTS	PACEMAKER	
ASTHMA	RHEUMATIC FEVER	**Please List Any Other Disease/Surgery Here**
BLEEDING ISSUES	SHINGLES	
CANCER	SKIN CONDITIONS	_____
CHEMICAL DEPENDENCY	STROKE	
COPD	THYROID	_____
DIABETES	TUBERCULOSIS	
EMPHYSEMA	SARCOIDOSIS	_____
EPILEPSY	SYPHILIS	
HEART CONDITION	LYME DISEASE	_____
HEPATITIS (TYPE ____)	RHEUMATOID ARTHRITIS	
HIGH BLOOD PRESSURE	AUTOIMMUNE DISEASE	

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? (CIRCLE)

DIZZINESS	EYE PAIN	CHEST PAIN	HORMONE PROBLEMS
ITCHY EYES	HEADACHE	SHORTNESS OF BREATH	NEUROLOGICAL ISSUE
EYE BURNING	BROWACHE	SKIN PROBLEMS	SEIZURE
HALOS AROUND LIGHTS	NAUSEA/VOMITING	URINARY PROBLEMS	LIGHT SENSITIVITY
BLURRED VISION	TROUBLE DRIVING	HEART ISSUES	MUSCULAR ISSUES

SOUTHERN CALIFORNIA EYE CONSULTANTS
NOTICE OF PRIVACY PRACTICES

How We Use and Disclose Your Information
We will obtain your written authorization for any uses and disclosures of protected health information (PHI)

Treatment, Payment, and Health Care Operations
We may use your PHI in order to provide your Medicare care; to bill for our services and to collect payment from you or your insurance company, and for the general operation of our business

Marketing, Fundraising, and Sale of PHI
We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without prior written authorization

We may use your PHI as otherwise authorized or required by law for such purposes as:

- Public health reporting and oversight activities
- Judicial, administrative, or law enforcement proceedings
- Complying with workers' compensation laws
- Communicating with your family or caregivers
- Sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI
- Request communications from us b specific means of locations
- Inspect and copy your medical record
- Ask us to correct the information in your medical records
- Receive an accounting of disclosures of your PHI by our practice
- Be notified in the case of a breach of unsecured PHI

ACKNOELEDGEMENT AND REQUESTED RESTRICTIONS
By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the practice, ands you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.
I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

FINANCIAL POLICY
Southern California Eye Consultants Inc. (SCEC) is committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. **Insurance**: SCEC will attempt to verify your benefits and coverage prior to your visit, however, there is no guarantee that your insurance company will pay for services rendered by our facility. Insurance coverage is a contract between the patient and the insurance company. It is your responsibility to provide us with your current address, telephone number, email address, and insurance information at each visit. We require that co-pays, applicable deductibles, and coinsurance be paid at the time of service. We will attempt to provide an estimate of charges at time of service. If a balance is incurred we will send you a statement for any outstanding balances.
2. **Referral and Pre-Authorizations:** You are required to 1) know whether or not your insurance requires a referral for medical and/or surgical treatment and 2) obtain that referral before you are scheduled to see one of our doctors. Our office will assist you in determining whether SCEC is a participating or non-participating provider. However, this is not a guarantee of coverage. Referrals typically have an expiration date and a limited number of visits, and it is your responsibility to monitor your referral status.
3. **No Insurance:** Private pay patients are expected to pay in full at the time of service unless prior arrangements have been made. You will receive a prompt pay discount on services provided when paid at the time of service.
4. **Returned Checks:** Your account will be charged $25 dollars for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the returned check and a $25 fee.

5. **Past Due Accounts:** A finance charge of 5.0% per month is assessed on all accounts not paid within 30 days. Patient who have not made an effort to make payment arrangements or have not met their financial obligation will be turned over to a collection agency. Once an account has been sent to collections, the patient must contact the collection agency for all correspondence regarding the balance. SCEC is authorized to automatically collect payment via credit card for any past due balance when credit card information is on file.
6. **Non-Covered Services:** SCEC will make a concerted effort to inform you if we believe a service may not be covered by your insurance company. In our professional judgment, these services are needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services, even if your insurance company denies payment
7. **Appointment Cancellations and No-Shows:** As a courtesy to our patients on the waitlist, if you need to cancel or reschedule your appointment, please give our office at least 24 hours notice of your scheduled appointment. Failure to give proper notice of cancellation or failure to show for your appointment MAY result in a charge of $25 to your account. If this happens, our office reserves the right to keep your credit card on file if you wish to reschedule. Thank you for your consideration.

ASSIGNEMNT OF MEICAL INSURANCE MEDICARE BENEFITS

I understand that I am financially responsible for any and all charges incurred during the course of authorized treatment I further understand that all applicable fees are due on the date that services are provided and agree to pay such charges in full. I hereby assign all medical and surgical benefits from my medical insurance and/or Medicare to SCEC, including major medical benefits, to which I am entitled. I authorize and direct my insurance carrier(s) to issue payment checks to SCEC for medical and surgical services rendered to me or my minor children. I understand that I am responsible for any amount not covered by my insurance benefits.

AUTHORIZATION TO RELEASE INFORMATION

I authorize SCEC to release any information necessary to insurance carriers regarding my treatments, process insurance claims generated in the course of examination, and allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. I authorize SCEC to disclose PHI, including lab results and diagnoses, in messages left on my voicemail at the following number (____) _____, and to the following person _____.

REFRACTION POLICY

The doctor performs a refraction to determine your glasses prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens make the images being viewed better or worse. A refraction is an essential part of a complete and comprehensive eye examination, but is **NOT** a covered service by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if this service is performed during your examination, a refraction charge of $55.00 will be collected today in addition to your copayment. **MEDICARE** does not every pay for refractions.

INFORMATION REGARDING DILATING EYE DROPS AND CONSENT TO TREAT

Dilating eye drops are used to enlarge the pupil of the eye to allow the Ophthalmologist to get a better view of the inside of your eye. These drops frequently blur your vision for a length of time which varies 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. I have requested medical services from SCEC for my or my child. I agree to and understand that my/my child's eyes may be dilated in order for the doctor to thoroughly check the optic nerve and retina. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of SCEC recommend that I find alternate transportation. I hereby authorize SCEC to administer dilating eye drops. These drops are necessary to diagnose my condition, if any exist.

I have read all the above policies. I understand all the above responsibilities for payment of services rendered and will fulfill my financial obligations for services rendered at SCEC.

Patient/Guardian Signature: _____ Date: _____