PATIENT DEMOGRAPHICS

DATE: ____________________

PATIENT NAME: ____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS: ____
(STREET) (APT/UNIT/SUITE)

____
(CITY) (STATE) (ZIP)

CELL PHONE: ____________________ HOME: ______________________EMAIL: _______________________

DATE OF BIRTH: _____________________ SS#: ________-________-__________ GENDER: ____________

OCCUPATION: ___________________________________ EMPLOYER: _________________________________

EMERGENCY CONTACT: ____
(NAME) (PHONE) (RELATIONSHIP)

May we leave a detailed message with this person?: Y / N

DO YOU HAVE AN OPTOMETRIST?

____
(OD NAME) (OFFICE ADDRESS) (PHONE)

WERE YOU REFERRED BY AN MD?

____
(MD NAME) (OFFICE ADDRESS) (PHONE)

HOW DID YOU HEAR ABOUT US? (Please write who/what)

FAMILY/FRIEND: ____________________ PHSYCIAN: _____________________ COMPANY: ____________________

MEDIA SOURCE: ____________________ EVENT: _____________________ OTHER: __________________________

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

MEDICARE PART B / MEDICARE ADVANTAGE PPO / OTHER CARRIER: ____________________________________

MEMBER ID #: ____ GROUP #: ______________________________

PRIMARY SUBSCRIBER/ INSURED: _____________________________ IS THIS A PPO, EPO, OR POS PLAN? Y / N

PRIMARY DATE OF BIRTH: ____________________ RELATIONSHIP TO PATIENT: ____________________________

SECONDARY INSURANCE (IF APPLICABLE)

CARRIER: _____________________________

MEMBER ID #: ____ GROUP #: ______________________________

PRIMARY SUBSCRIBER/ INSURED: _________________________________

PRIMARY DATE OF BIRTH: ____________________ RELATIONSHIP TO PATIENT: ____________________________

PATIENT/LEGAL GUARDIAN SIGNATURE: ____

LEGAL GUARDIAN NAME & PHONE: ____

Patient's Preferred Pharmacy Information

I, __________________________ would like the Assil Gaur Eye Institute to send my ePrescriptions to the following pharmacy:

Pharmacy Name: ____

Pharmacy Address: ____

____

Pharmacy Phone #: ____

Other Information: ____

Please provide as much information as you can to ensure that we send your prescriptions to the correct pharmacy.

Thank you!

Assil Gaur Eye Institute and Staff

FINANCIAL POLICY

Thank you for choosing Assil Gaur Eye Institute as your trusted medical vision care specialist. We are committed to providing you with the highest level of service and quality care.

If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as well as **routine eye exams** provided by our Optometrists. We do not participate with **ANY** vision plans (VSP/Davis Vision, etc.). **We do not participate with any HMOs.**

ACKNOWLEDGEMENT OF BILLING PRACTICES

- **Payment Due**: I understand that payment is due when service is rendered.
- **Co-pay, Co-insurance and Deductibles.** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service. I understand that deductibles reset at the beginning of the calendar year, therefore collection for services may reflect accordingly.
- **Billing Fee:** If I am not able to pay my co-pay, deductible or co-insurance portion at the time of service my appointment may be rescheduled or may be subject to a **$20.00** billing fee.
- **Billing Balances:** I understand that I must pay any outstanding balances prior to services rendered. If I receive a billing statement in the mail, it is my responsibility to pay the balance. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to **$30** collection charges, penalties and interest.
- **Non-covered Services**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Refractions**: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription. Medicare and most medical insurance do not cover the fee for refractions. I understand that I am responsible for a **$75** fee payable at the time of service.
- **Denied Charges**: I understand that some charges may be denied by my insurance carrier as investigational, experimental, or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deem them payable or not and that I am obligated to pay for these services in full.

- **Insurance Coverage**: I acknowledge that the insurance cards I have presented are current and accurate. Presenting a card with which we do NOT participate is not sufficient disclosure to waive the cost of services.
- **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for paying in full at the time of service. Presenting a card with which we do NOT participate is not sufficient disclosure to waive the cost of services.
- **Medicaid:** The practice will accept MediCal's LA Care and HealthNet plans when secondary to Medicare. We do NOT accept LA Care HMO or HealthNet HMO as the primary insurer. I understand that I am responsible for my copay at the time of service and if I have exceeded my yearly allotted visits that I am responsible for paying for my visit in full at the time of service. I understand I may be responsible for a share of cost with MediCal and will be billed when applicable.
- **Medical Plans that have Vision Benefits**: Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. Eye health disorders are typically covered under medical (not vision) plans. We may be participating providers with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether the practice is a provider for both your medical and vision plan.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to communicate what you will owe for surgical charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur addition charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory, or radiologist.
- **Authorizations**: Some insurance plans require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and if you would like your insurance to approve your benefits, please obtain this authorization prior to your visit with our clinic.
- **Forms**: There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.
- **Cancellation and No Shows**: We request 24 hours prior notice for all appointment cancelations or changes. We reserve the option to apply a **$50.00** charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Legitimate emergencies will be taken into consideration.

I have read and understand the above financial policy.

____ ___________________

Signature of patient/guardian/parent Date

____

Printed name of patient

If you would like a printed copy of the financial policy please inform the receptionist.

HIPPA PRIVACY PRACTICES NOTIFICATION
AND PREFERENCES FOR COMMUNICATING PERSONAL HEALTH INFORMATION

This form is acknowledgement that you have received our Notice of Privacy Practices.

Name of Patient: ______________________________________
[Please Print]

Date of Birth: ______________________________________

To respect your privacy please tell us which of the following numbers we should call to communicate with you regarding appointment reminders etc. Only list the phone number(s) you would like us to call.

Please specify if a message can be left on an answering machine or voicemail, with a spouse or significant other or with another designated person.

Home: ____________________ Message: Yes [ ] No [ ]

Work: ____________________ Message: Yes [ ] No [ ]

Cell: ____________________ Message: Yes [ ] No [ ]

Other: ____________________ Message: Yes [ ] No [ ]

Email: ____

My Personal Health Information may be communicated to the following people:

1. ____ (______)_________________________
2. ____ (______)_________________________
3. ____ (______)_________________________

Patient/Guardian Signature: ____ Date: _____________

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ Date: ______________

Date of Birth: __________ Ethnicity: ______________ Date of Last Eye Exam: __________

List ANY medications you currently take (prescription and over-the-counter): ______________

Do you have allergies to any medications? ☐ YES ☐ NO *If YES, list the medications below*

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, stroke, etc.) or injuries/accidents:

List any eye related surgeries you have had (LASIK, cataract, glaucoma, retinal, etc.) ______________

List any other surgeries you have had (cardiac bypass, appendectomy, etc.) ______________

Do you currently have any problems in the following areas? **If *"YES," please provide information*.**

HEALTH	*Yes*	*No*	*Explanation of Problem*
EYES (glaucoma, cataract, retinal disease, etc.)	☐	☐	
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Fluctuating vision	☐	☐	
Distorted vision (halos, stars)	☐	☐	
Double vision	☐	☐	
Dry eyes	☐	☐	
Mucous discharge	☐	☐	
Redness	☐	☐	
Sandy or gritty feeling	☐	☐	
Itching or burning	☐	☐	
Foreign body sensations (eyelash, etc.)	☐	☐	
Eyes tearing or watering	☐	☐	
Light or glare sensitivity	☐	☐	
Eye pain or soreness	☐	☐	
Infection of eye or lid (blepharitis, stye)	☐	☐	
Tired eyes	☐	☐	
Crossed eyes or lazy eye	☐	☐	
Drooping eyelid or puffy upper or lower lids	☐	☐	
Do you want to see clearly without glasses?	☐	☐	
Do the lines around your eyes or forehead bother you?	☐	☐	
GENERAL HEALTH			
Fever	☐	☐	
Weight loss or weight gain	☐	☐	
Other	☐	☐	
EARS, NOSE, THROAT			
Sinus infections	☐	☐	
Ear infections	☐	☐	
Chronic cough or dry mouth, etc.	☐	☐	

HEALTH (Cont'd)	*Yes*	*No*	*Explanation of Problem*
Cardiovascular (heart, vessels, etc.)	☐	☐	
Respiratory (asthma, emphysema, etc.)	☐	☐	
Gastrointestinal (ulcers, intestinal disease, etc.)	☐	☐	
Genital, Kidney, Bladder	☐	☐	
Muscles, Bones, Joints (arthritis, etc.)	☐	☐	
Skin (acne, warts, skin cancer, etc.)	☐	☐	
Neurological (stroke)	☐	☐	
Psychiatric (anxiety, depression, insomnia, etc.)	☐	☐	
Endocrine (diabetes, hypothyroid, etc.)	☐	☐	
Blood/Lymph (high cholesterol, anemia, etc.)	☐	☐	
Allergic/Immunologic) **(**Lupus, Sjogren's, hay fever, rashes)	☐	☐	
HIV	☐	☐	

FAMILY HISTORY

M=MOTHER F=FATHER S=SIBLING GP=GRANDPARENT

DISEASE	*Yes*	*No*	RELATIONSHIP TO PATIENT
Blindness	☐	☐	
Glaucoma	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart disease or high blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Other	☐	☐	

SOCIAL HISTORY

Current Occupation: ______________________

Education (high school, vocational school, college degree) ______________________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Are you active in sports or hobbies? If so, please list. ______________________

Do you have special living arrangements or a caregiver? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No Do you have trouble seeing while driving? ☐ Yes ☐ No

Is it difficult for you to see at night or in dim light? ☐ Yes ☐ No ______________________

Have you ever worn contact lenses ☐ Yes ☐ No Do you currently wear contact lenses ☐ Yes ☐ No

If YES, how long have you worn contact lenses? ______________ Soft or hard lenses? ☐ Soft ☐ Hard

Do you currently wear glasses? ☐ Yes ☐ No How long have you had the current prescription? ______________

Do you have any problems with your frames or your prescription? (frames slipping, scratched lenses) ☐ Yes ☐ No

Do drink alcohol? ☐ Yes ☐ No If yes: ☐ occasionally ☐ 1 per day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ Yes ☐ No If yes: ☐ occasionally ☐ ½ pack/day ☐ 1 pack/day ☐ 2+ pack/day

Have you ever had a blood transfusion? ☐ Yes ☐ No Have you ever had Hepatitis? ☐ Yes ☐ No

History Reviewed ☐ No Changes ☐ Additions as noted above

Physician's Signature:		Date:	

Screening for Aerosol Transmissible Diseases (ATD)

Patient Name: ____

In compliance with California OSHA Title 8, Section 5199, health care facilities must prescreen patients for aerosol transmissible diseases (ATD). We use this Form to pre-screen a patient to determine whether the patient may present an ATD exposure risk.

Tuberculosis:

Do you have a history of Tuberculosis? Yes ( ) No ( )

If Yes, explain: ____

Do you have?

Productive cough	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Bloody sputum	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Night sweats	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Fatigue	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Malaise	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Fever	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Unexplained weight loss	Yes ( ) How long? _____________	Explain: ____________________________	No ( )

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis, MRSA:

Do you have?

Fver?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Body aches?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Runny nose?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Sore Throat?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Headache?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Nausea?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Vomiting?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Diarrhea?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Respiratory symptoms?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Severe coughing spasms?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Painful, swollen glands?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Skin rash-blisters?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Stiff neck?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )
Mental changes?	Yes ( ) How long? _____________	Explain: ____________________________	No ( )

Chronic Respiratory Diseases (NOT ATD's, and not considered Infectious) do not disqualify a patient from treatment, Do you have (circle): Chronic upper airway cough syndrome "postnasal drip," Gastro esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), Bronchitis, Emphysema, Allergies, Asthma.

Do you have?

Chronic upper airway cough syndrome "postnasal drip"?	Yes ( ) Explain: ______________________________	No ( )
Gastro esophageal reflux disease (GERD)	Yes ( ) Explain: ______________________________	No ( )
chronic obstructive pulmonary disease (COPD)	Yes ( ) Explain: ______________________________	No ( )
Dry cough from ACE inhibitors?	Yes ( ) Explain: ______________________________	No ( )
Bronchitis	Yes ( ) Explain: ______________________________	No ( )
Emphysema	Yes ( ) Explain: ______________________________	No ( )
Allergies	Yes ( ) Explain: ______________________________	No ( )
Asthma	Yes ( ) Explain: ______________________________	No ( )

____ ___________________

Patient/Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.**

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Practice Administrator at (310) 651-2302. Effective 3/30/16

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.