

NEW PATIENT INFORMATION

1. Name _____ Date _____
2. Mailing Address _____
3. City _____
4. State _____ Zip Code _____
5. Date of birth ___ / ___ / ___ Age ___ Gender ___ Soc. Security # _____
6. Telephone (home) _____ (work) _____
7. Occupation _____ Employer _____
Address/Phone _____
8. Please circle single married widowed divorced
Name of spouse _____ Employer _____
Date of birth _____ Social Security # _____
9. Complete if under 18 years or a student
Name of Father _____ Employer _____
Address/Phone _____
Date of Birth ___ / ___ / ___ Soc. Security# _____
Name Mother _____ Employer _____
Address/Phone _____
Date of Birth ___ / ___ / ___ Soc. Security # _____
10. Referral Source (Patient, Doctor, Advertisement)

11. Primary Insurance Company _____ Number _____
Secondary Insurance Company _____ Number _____
Workers Compensation (job injury)
Employer _____ Phone# _____
12. Whom to notify in emergency (nearest relative)
Name _____ Relationship _____
Address _____
Home Phone _____ Work Phone _____
13. Preferred phone number of Appointment Reminder
Phone # _____
14. Do we have your permission to leave a voicemail message if the office needs to contact you regarding appointments, test results, etc.? Yes No Initial _____

Responsible Party's Signature

Patient's Signature

Date

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List all **medications** you currently take (Rx and over-the-counter): _____

Do you have **allergies** to any medications? **YES NO**
 If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, appendectomy): _____

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

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
 Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

Have you ever had a blood transfusion? **YES NO**

Do you drink alcohol? **YES NO** If YES, how much? _____

Do you smoke? **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ Date _____

Refraction Policy

One of the most important parts of our eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and most other insurance plans. These plans consider refraction a "vision" service not a "medical" service.

Our office fee for refraction is \$50.00, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

Signature

Date

I decline the refraction service today. I understand that without the refraction, Dr. Husted, Dr. Rosenblum, or Dr. Penrose may not be able to fully assess the health and function of my eyes.

Signature

Date

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print)

Medicare Number / Private Insurance

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* for services furnished me by *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose*. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* 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 HCFA 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 *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose*, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* 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 *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* for reimbursement for services rendered, and (2) any health care provider for continued patient care. They 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 *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* has no contract, expressed or implied, with any plan that *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* is not contracted. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* if I belong to a plan that *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* is not contracted.

5. **NON-COVERED SERVICES:** I understand that *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose'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 *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose*, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose* 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 *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose*. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to *Dr. Roger Husted, Dr. Leland Rosenblum, or Dr. Philip Penrose*. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Monterey Bay Eye Center
Roger C. Husted, M.D.
Leland H. Rosenblum, M.D.
Philip J. Penrose, M.D.
21 Upper Ragsdale Drive, Suite 200
Monterey, California 93940
(831) 372-1500
Fax (831) 655-6493

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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payer.
- Conduct normal healthcare 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 disclosures 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 the *Notice of Privacy Practices*.

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 health care 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: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below

Date:	Initials:	Reason:
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NOTICE OF PRIVACY PRACTICES

MONTEREY BAY EYE CENTER
Roger C. Husted, M.D.
Leland H. Rosenblum, M.D.
Philip J. Penrose, M.D.
21 Upper Ragsdale Drive, Suite 200
Monterey, California 93940
(831) 372-1500
Fax (831) 655-6493

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

(over)

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You have the right to inspect and copy most of your medical information maintained by us. Normally, we will provide you with access within 30 days of your request. We may charge a reasonable copying fee. In certain limited instances, we may deny you access, for example, when the request is for psychotherapy notes. You have the right to a review of denial of access to your medical information. Any request to inspect and copy medical information should be made to the Privacy Officer.
- The right to amend your protected health information. You have the right to request that we amend your written medical information. For instance, you can request that we correct an incorrect surgery date in your records. We will generally amend your information within 60 days of your request, and will notify you when we have amended your information. We can deny your request in certain circumstances, such as when we believe that your information is inaccurate and incomplete. You can file a statement of disagreement to a denial of your request for amendment, to which we may file a rebuttal. Please direct any request to amend your medical information to the Privacy Officer.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

If you wish to see our more detailed Notice of Privacy Practices which includes legal reasons we might be required to disclose your "PHI", ask at our front desk, or write to our address below.

Please contact us for more information by writing to:

Privacy Officer
 C/O Monterey Bay Eye Center
 21 Upper Ragsdale Dr. #200
 Monterey, California 93940

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
 Office of Civil Rights
 200 Independence Avenue, S.W.
 Washington, D.C. 20201
 (202) 619-0257
 Toll Free: 1-877-696-6775