Monterey Bay Eye Center

Patient Registration

Name: ______________________________ **Soc.Sec. #:** ________________

Last First Middle

Sex: ☐ M ☐ F **Age:** _____ **Date of Birth:** ___________

Address: ____

City: ______________________________ State: ___________ Zip: _________

Home Phone: ________________ **Mobile(Cell) Phone:** ____________________

Preferred Method of contact (circle one): Home / Mobile (Cell)

May we send appointment reminders to your mobile device? (circle one) YES / NO

Email address: ____

Marital Status: ☐ Single ☐ Married

Preferred Language: ________________________

Race (optional, please check one):

☐ African-American/Black ☐American-Indian or Alaskan Native ☐Asian ☐Caucasian/White

☐Hispanic ☐Native Hawaiian or Other Pacific Islander ☐Other:___________ ☐Declined to Provide

Ethnicity (please specify or decline) : ______________________ ☐Declined to Provide

Patient Employed by: ______________________ **Business Phone:** ______________

Primary Care Doctor: ________________ **Referring Doctor:** __________________

In case of emergency who should be notified?

Name: ____________________ **Phone:** ______________ **Relation:** ___________

How did you hear about us? ☐**Word of Mouth** ☐ **Insurance** ☐**DMV** ☐ **Other:** ______________

INTERNET: ☐ Our Website ☐ Facebook ☐Google ☐VSP Website ☐AAO

NEWSPAPER/PRINTED: ☐The Carmel PineCone ☐ Herald (Directory/HealthMatters) ☐ Yellow Pages

REFFERRAL: ☐ Referring Physician ☐ Established Patient: ____________________

MONTEREY BAY
EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

21 Upper Ragsdale Drive, Suite 200
Monterey, CA 93940
P: #831.372.1500 • F: #831.655.6493
montereybayeyecenter.com

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, etc.).

____

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)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, 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, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other: ______________________________

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

Primary Insurance

Name of Insured: ____

Last First Middle

Relation to Patient: ________________ **Birthdate:** ______________ **Soc.Sec. #:** ______________

Person Responsible Employed by: ____________________________ **Phone:** ________________

Insurance Company:

____

Secondary Insurance

Name of Insured: ____

Last First Middle

Relation to Patient: ________________ **Birthdate:** ______________ **Soc.Sec. #:** ______________

Person Responsible Employed by: ____________________________ **Phone:** ________________

Insurance Company:

____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

MONTEREY BAY
EYE CENTER

REFRACTION POLICY

One of the most important parts of your eye exam is the refraction service. This is the test that we perform with you looking at an eye chart through multiple sets of lenses, until we find the glasses or contact prescription that allows you to see optimally. Refraction also provides us with important information about the function of your eyes and may alert us to any problems that are related to a decrease in visual acuity.

Unfortunately, medical insurances do **NOT** cover this service as they have determined that it is not "medically" necessary. However, if you have vision insurance that covers this service (such as Tricare Prime or Vision Service Plan-VSP), the refraction **IS** a covered service. Please check with your insurance carrier for eligibility and benefits information (Copays may apply).

Our fee for refraction is **$60.00**, and unless you have vision insurance that covers the refraction charge, this fee is **due at the time of service** in addition to any co-payment your plan requires.

Please select and sign below:

☐ **Yes, I consent to receive the refraction service.** I accept full financial responsibility for the cost if I do not have vision insurance that covers this.

☐ **No, I decline to receive the refraction service.** I understand that the doctor may not be able to fully access the health and function of my eyes.

Print Name: ______________________________________

Signature: ____

Date: ______________

MONTEREY BAY
EYE CENTER

CONTACT LENS FITTING AND EVALUATION POLICY

21 Upper Ragsdale Drive, Suite 200
Monterey, CA 93940
P: #831.372.1500 • F: #831.655.6493
montereybayeyecenter.com

Contact lenses are considered medical devices, and as such require measurements and evaluation for appropriate fitting, and training by an eye care professional. For current contact lens wearers, it is important that your contact lenses are evaluated annually to ensure that your vision and eye health with the contact lenses are optimized in order to renew your contact lens prescription. Contact lens evaluation for proper fitting requires additional time and measurements. A fee for this service, which is not part of your medical eye exam, will be applied based on the complexity of your prescription.

☐ I would like contact services, and I have read and understand the above Contact Lens Fitting and Evaluation Policy.

☐ I decline contact lens services.

______________________________ Patient/Guardian's 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 Drs. Husted, Rosenblum, Shi and Nakajima for services furnished to me. 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. Drs. Husted, Rosenblum, Shi and Nakajima accept 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 Drs. Husted, Rosenblum, Shi and Nakajima if possible or otherwise to me.

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

5. **NON-COVERED SERVICES:** I understand that Drs. Husted, Rosenblum, Shi and Nakajima'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 Drs. Husted, Rosenblum, Shi and Nakajima to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Drs. Husted, Rosenblum, Shi and Nakajima, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Dr. Husted 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 Drs. Husted, Rosenblum, Shi and Nakajima. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Drs. Husted, Rosenblum, Shi and Nakajima. *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 _______________

MONTEREY BAY EYE CENTER

No-Show/Cancellation Policy
Quality Care for our patients is our priority. Please take a few minutes to review our no-show policy and sign the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

Monterey Bay Eye Center defines a "No-Show" appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours (1 business day) notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

⇒ Potentially jeopardizes the health of the "no showing" patient
⇒ Is unfair (and frustrating) to other patients that would have taken the appointment slot
⇒ Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 10-15 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

Monterey Bay Eye Center will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will have to call Monterey Bay Eye Center to change/cancel your appointment if necessary. your appointment Office Phone Number: 831-372-1500.

2. Always Arrive 10-15 Minutes Early

When you schedule an office visit with us, we expect you to arrive 10-15 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit. Please allow time for parking, at times our lot can be congested enough to make you late to your appointment.

3. Give 24 Hours' Notice if you Need to Cancel

When you need to reschedule/cancel your appointment, we expect you to contact our office no later than 24 hours before your scheduled visit. This allows reasonable time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook a now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us a courtesy call.

Consequences of "No-Show" Appointments

1. **Patient will be charged a $45.00 for every "No Show "**
2. If you miss 3 or more appointments within 1 year you may be dismissed from our practice. Patient dismissal is at the discretion of your provider.

I have read and understand Monterey Bay Eye Center's No-Show/Cancellation Policy and understand my responsibility to plan appointments accordingly and notify Monterey Bay Eye Center appropriately if I have difficulty keeping my scheduled appointment.

______________________________ ________________
PATIENT NAME (PRINT) DATE

____
PATIENT SIGNATURE OR PARENT/GUAURDIAN IF MINOR

MONTEREY BAY
EYE CENTER

NOTICE OF PRIVACY PRACTICES

21 Upper Ragsdale Drive, Suite 200
Monterey, CA 93940
P: #831.372.1500 • F: #831.655.6493
montereybayeyecenter.com

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 my designated 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 restictions, 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:

MONTEREY BAY
EYE CENTER

Leland H. Rosenblum, M.D.
Anna J. Shi, M.D.
Roger C. Husted, M.D.
Kasey N. Nakajima, O.D.

Patient Name:

Optional Screening PHOTOS Of The Inside Of Your Eyes

An exam of the retina (the inner lining of your eyes) can lead to early detection of common eye diseases, as well as **signs of other diseases including hypertension, diabetes, and even brain tumors.** Unfortunately, patients may experience some discomfort during the exam which involves dilated pupils and a bright exam-light.

Optional screening photos offer several advantages:

1. Painlessly captures retinal images in just a few seconds.
2. Reduced amount of time and light that the doctor needs for examination because the Screening photo directs the doctor where to concentrate.
3. Usually start with weaker dilating drops; sometimes stronger drops may be required.
4. The **camera** produces stable **wide field** high resolution **photos** which your doctor Required.
5. The images become part of your medical record, enabling your doctor to make important comparisons if problems show up in the future.

Because this is considered a screening examination,

It is **NOT COVERED by health insurance.**

If it is within your budget, we recommend these photos to enhance the effectiveness and comfort of your eye exam.

☐ I choose screening digital retina photos **COST $75.00**

☐ I choose traditional dilated retinal exam (usually covered by medical insurance, except for usual deductibles and co-pays)

Patient Initials: ________________ Date: ______________

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