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 Registration

Name: _____ **SSN:** _____

Last, First Middle

Sex: ☐ Male ☐ Female **Age:** _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Preferred Method of contact (circle one): Home / 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 or decline):

☐ 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**

Primary Care Doctor/Physician: _____

Referring Doctor/Physician: _____

In case of emergency who should be notified?

Name: _____ **Phone:** _____ **Relation:** _____

Is this person authorized to receive medical appointment information and/or history? **Yes / No**

How did you hear about us? ☐**WORD OF MOUTH** ☐ **INSURANCE LIST** ☐**DMV**

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

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

☐ **REFERRAL:** ☐ *Referring Doctor/Physician* ☐ *Established Patient*: _____

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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 PATIENTS Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

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MEDICAL HISTORY

Name_____ Today's Date: _____

Date of Birth: _____ Date of **last eye exam:** _____

What **medications** (Rx & OTC) do you currently take (**OR** *provide list for us to copy*)?

_____

Are you allergic to **latex**? (circle one) **YES** OR **NO**
Do you have any **allergies** to any medications? **YES** OR **NO**
If **YES**, list the medications:

_____

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

_____

List any **surgeries** (cataract, Lasik, PRK, appendectomy, etc.):

_____

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

	YES	NO	Explanation of problem
EYES (poor vision, eye pain, tearing/redness)			
GENERAL / CONSTITUTIONAL (fever, weight loss/gain, fatigue)			
EARS, NOSE, THROAT (hard of hearing, cough, earache, sore throat, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (wheezing, short of breath, congestion, etc.)			
GASTROINTESTINAL (upset stomach, constipation, diarrhea, ulcers, hernia, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, cramps, arthritis, etc.)			**Have you fallen in the past year or feel unsteady when standing/walking? Yes OR No**
SKIN (Pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (Headache, seizures, paralysis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			**LAST A1C RESULT (diabetic patients):**
BLOOD, LYMPH (Anemia, bleeding)			
ALLERGIC, IMMUNOLOGIC (swelling, hives, Lupus etc.)			

FAMILY HISTORY (mother, father, sibling, grandparent)
Has there been any family history of (Circle all that apply): **Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer Thyroid Disease, Arthritis, Other:** _____

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

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REFRACTION POLICY

(GLASSES PRESCRIPTION)

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 **$75.00**, 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: _____

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CONTACT LENS FITTING AND EVALUATION POLICY

Contact lenses are considered medical devices, and as such require measurements and evaluation for appropriate fitting/training by an eye care professional. For current wearers, it is important that your contact lenses are evaluated annually. This ensures that your vision and eye health with the contact lenses are optimized 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 A COVERED** part of your medical exam, will be applied based on the complexity of your prescription.

□ **YES**, I would like the above-mentioned contact lens services and understand the fitting and Evaluation Policy.

□ **NO**, I decline contact lens services.

_____ _____

Patient/Gaurdian's Signature **Date**

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Optional Screening Photos

A photographic image of the retina (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.

Screening photos advantages:

Painlessly capture retinal images in just a few seconds.

Photos direct the doctor where to concentrate the examination.

The camera produces stable wide field, high-resolution photos that become part of your medical record enabling the doctor to make important comparisons if problems show up in the future.

*This is considered an optional screening exam; it is **NOT COVERED** by health insurance.*

We strongly recommend these photos to enhance the effectiveness and comfort of your eye exam.

□ **YES,** I choose screening digital retina photos **COST $75.00**

□ **NO,** I choose traditional dilated retinal exam **(USING DILATING DROPS)**

Patient Initials: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.
- Help with public health and safety issues
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

I have received, read, and understood 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.

Printed Name of Patient: _____ **Date:**_____

Signature of Patient/Guardian: _____ **Relation:**_____

OFFICE USE ONLY

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

Date:	**Initials:**	**Reason:**

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Signature on File, Assignment of Benefits, Financial Agreement

Patient/Beneficiary Name *(print)* _____ Date of Birth _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Drs. Rosenblum, Shi, Husted and Nakajima, for services furnished to me by my provider. 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. My provider 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 Drs Rosenblum, Shi, Husted and , if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** Drs. Rosenblum, Shi, Husted 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. Rosenblum, Shi, Husted and Nakajima for reimbursement for services rendered, and (2) any health care provider for continued patient care. Drs. Rosenblum, Shi, Husted 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. Rosenblum, Shi, Husted and Nakajima have no contract, expressed or implied, with any plan that they are not contracted. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Drs. Rosenblum, Shi, Husted and Nakajima if I belong to a plan that they are not contracted with.
5. **NON-COVERED SERVICES:** I understand that Drs. Rosenblum, Shi, Husted and Nakajima 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. Rosenblum, Shi, Husted 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. Rosenblum, Shi, Husted and Nakajima, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to them 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. Rosenblum, Shi, Husted and Nakajima. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Drs. Rosenblum, Shi, Husted and Nakajima. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.***

Patient/Beneficiary Signature _____ **Date** _____

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CANCELLATION / "NO SHOW " POLICY

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 15 minutes late and is consequently unable to be seen

1. Cancellation/No Show Policy for Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If an appointment is not canceled at least 24 hours in advance, you will be charged directy a **forty-five-dollar ($45) fee for every "NoShow"**; your insurance company **will not** cover this.

2. Scheduled Appointments
We understand that delays can happen however, we must keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule/cancel the appointment.

If you need to cancel and/or reschedule your appointment, please call us at least 24 hours in advance. We can be reached at 831-372-1500.

Patient/Gaurdian Signature: _____

Patient/Gaurdian Name (Print): _____

Date: _____