CALIFORNIA OCULOPLASTICS AND RETINA

(626) 653-9395

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ____________

Contact Restrictions: ____________ Drivers License # (include State) ____________

Age ____ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

Emergency Contact

____________ Relationship to Patient ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Address ______________________________
Street & Apt # City State Zip

Referring Physican ____________ Phone ____________

Primary Care Physican ____________ Phone ____________

Primary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

Signature ______________________________ **Date** ____________

Authorization to Receive/Release Health Information

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** It is mandatory that we ask you to review and answer the following questions listed below.

Patient Name ____
Last First Middle

May we leave messages/detailed medical information on voicemail at either of these phone numbers?
☐ Yes ☐ No Home Phone: ___________________ ☐ Yes ☐ No Cell Phone: ____________________

May we contact you at your place of employment? ☐ Yes ☐ No
If so, may we leave a message? ☐ Yes ☐ No

If yes: Work Phone: _______________________ Extension: _______________

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

☐ Yes ☐ No If yes, please provide:

Name: ____________________________ Relationship: _______________________

Phone Number: _________________________ Alternative Number: ____________________________
Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

Name: ____________________________ Relationship: _______________________

Phone Number: _________________________ Alternative Number: ____________________________

I hereby authorize **California Oculoplastics and Retina** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have review the aforementioned information and provided my consent regarding any and all the issues as stated above.

I have reviewed **California Oculoplastics and Retina** Notice of HIPPA Privacy Policy. A copy of this policy will be provided to me upon request.

Signature ____ **Date** ______________________

Office Representative:___________________________________

For Office Use Only:
Please initial this page _________ Date:__________

Patient Name ____
Last First Middle

UNDERSTANDING YOUR FINANCIAL RESPONSIBILITY

Your Financial Responsibility
Our medical services are provided to you with the understanding that you are responsible for any costs regardless of your insurance coverage. For self-pay patients or those using insurance, payment is due on the day services are rendered. For your convenience, we accept various payment methods, including cash, checks, credit/debit cards, and Promptly. To discuss payment options, please contact our billing department prior to your appointment.

Insurance
Your insurance policy is a contract between you and your insurance company; our practice is not a party to this contract. As a courtesy, we will bill your insurance, provided we have accurate, up-to-date information. Please bring your insurance card to each appointment and disclose all relevant details, including any primary, secondary, or updated insurance information. Notify us promptly of changes to your address, name, or insurance to ensure accurate billing.

It is also your responsibility to understand your insurance coverage, including co-pays, co-insurance, and deductibles. Payment for these charges is expected at the time of your visit or when billed. Any non-covered services or deductible charges are also your responsibility, as we cannot waive or discount these amounts under insurance requirements.

Non-Covered Services and Denials
Insurance plans vary in what they consider medically necessary. If your insurance does not cover certain services, or if your coverage has lapsed or expired, you will be responsible for the full cost. If you choose not to use your insurance benefits or if your insurance denies coverage, you are responsible for all charges. Please review your insurance plan for specific coverage details, or contact your insurance provider for clarification on covered services.

Network Status: In-Network vs. Out-of-Network
Our practice participates with many insurance plans, but it is the patient's responsibility to confirm whether we are in-network or out-of-network under their plan. In-network coverage typically results in lower out-of-pocket costs, while out-of-network care may incur higher deductibles or co-insurance. We recommend contacting your insurance provider to verify our network status before receiving care.

Prior Authorization
Some insurance plans, particularly HMO and PPO plans, may require prior authorization or a referral from your Primary Care Physician (PCP) to receive services. Please bring this authorization or referral to your appointment. If authorization is not obtained, or services exceed the authorized scope, you may be responsible for the costs.

Patient Cost Estimate
Our practice can provide a rough estimate of your financial responsibility based on your insurance benefits. Please keep in mind that this is only an estimate, as we will not know the exact amount until we receive an Explanation of Benefits (EOB) from your insurance provider. The final amount may vary depending on how your insurance processes the claim.

Late Fee and Collections
If a balance remains unpaid and no payment arrangements have been made, the account may be classified as delinquent. All unpaid balances will be charged a 2% late fee, calculated based on the outstanding balance, until the account is brought current or a payment arrangement is established.
Delinquent accounts are subject to be sent to an external collection agency once the balance is more than 90 days old and multiple collection attempts have been made. Accounts sent to an external collection agency may incur collection, attorney, or court fees, which will be the patient's responsibility. Additionally, unpaid accounts may impact your credit.

Acknowledgement
I have read and understand the financial policies outlined above, including my responsibility to verify insurance coverage, obtain prior authorizations if required, and pay for any non-covered services, co-pays, co-insurance, and deductibles. I acknowledge that any services deemed not medically necessary, services rendered out-of-network, or services not covered by my insurance plan will be my financial responsibility. Should my insurance deny coverage or payment for any reason, I agree to pay all associated charges in full.

Signature ________________________________ **Date** ______________________

For Office Use Only:
Please initial this page _________ Date:__________

California Oculoplastics
California Retina

625 South Fair Oaks Avenue Suite 260
Pasadena, CA 91105-2667
ph: (626) 653-9395 **fx**:

Insurance Waiver Form

Please read through this waiver form, find the section that applies to you and if applicable, sign and date.

Patient Name: **DOB:**

Self-Pay Patient Without Health Insurance

- If you do not have insurance, you are a self-pay patient. Please sign the waiver below.

I acknowledge that I DO NOT have insurance and have elected to be seen as a SELF-PAY patient. I am agreeing to assume ALL financial responsibility. This agreement pertains to today's and all future visits.

Signature: ___________________________________ Date: ______________________

Managed Care or HMO Plan Requiring a Referral

- If your insurance company requires you to obtain a referral in order to see a specialist, your Primary Care Physician or Referring Physician must authorize your visit to the specialist BEFORE the visit occurs.

I acknowledge that I have to obtain an authorization referral from my Primary Care Physician or Referring Physician. I am agreeing to assume ALL financial responsibility. This agreement pertains to today's visit and all future visits without an authorization.

Signature: ___________________________________ Date: ______________________

Out of Network Insurance Plan

I acknowledge that I have been informed that my insurance carrier is OUT OF NETWORK therefore, is not accepted. I am agreeing to assume ALL Financial Responsibility. This agreement pertains to today's and all future visits with this insurance carrier.

Signature: ___________________________________ Date: ______________________

For Office Use Only:
Please initial this page _________ Date:___________

Patient Consent For Photography/Videotaping/ Audiotaping/ Interviewing For Educational, Marketing, Media, Performance Improvement, or Law Enforcement Purposes

Patient Name ____
Last First Middle

I hereby give my consent to **California Oculoplastics and Retina or its Affiliates** to take photographs, videotape images, or other images of myself or my minor child, interview and take written notes, as well as make audio recordings of the interview. This would be done for one or more of the following purposes:

Insurance, Education, Performance Improvement, Publicity or Organizational Marketing.

I further understand that all photographs, audio tapes, videotapes or interviews taken for purposes of education and/or performance improvement will be protected health information and will be maintained in a protected and secure manner with access restricted to the minimum necessary to carry out the above stated functions.

I understand that photographs, audiotapes, videotapes or interviews taken for purposes of law enforcement become the property of the legal entity making the recordings and could be used in a court of law.

I understand the photographs, audiotapes, videotapes and interviews taken for marketing or publicity purposes may be used for publications and/or broadcast by the media for public affairs purposes, including publications, advertisement, displays and/or placement on the **California Oculoplastics and Retina** website. I hereby waive all the rights that I may have to any claims for payment or royalties in connection with the use of these photographs, audiotapes, videotapes and interviews, and agree that these shall at all times be property of **California Oculoplastics and Retina** or the media representative present.

I hereby release **California Oculoplastics and Retina** or any of its affiliates, employees, or agents from all liability, including and claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from, the taking and authorized use of these photographs, audiotapes and interviews.

I further understand that this consent is subject to revocation/withdrawal by me at any time in writing to the appropriate person except to the extent that action has already been taken to release the information.

□ only use my photos for insurance and internal purposes

Signature ____________________________________ **Date** ____________________
Signed by parent if patient is a minor child

Office Representative:________________________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contact or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, association, corporations, partnership, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case if any pregnant mother, the term "patient" here in shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure SS 1280-1295 and the Federal Arbitration Act (9 U .S.C. SS 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of the signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California Law.

I understand that I have the right to receive a copy of this agreement. By signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.
SEE ARTICLE 1 OF THIS CONTRACT.

By:____
Physician's or Duty (Date)
Authorized Representative Signature

By:____
Patient Signature (Date)

By:____
Print Patient's Name

By:____
Signature or Translator (if applicable) (Date)

____
Print Name or Relationship to Patient

____
Print Name of Translator

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.

For Office Use Only:
Please initial this page _________ Date:__________

California Oculoplastics
California Retina

Health Questionnaire

First name______________________ Middle Name_________________ Last Name_______________________

Social history		Personal Habits	
Marital Status:	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic partner	**Tobacco Use:**	❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoker ❑ Smoker, current status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker Date Started: ________________ Date Ended: ________________
Occupation:			
Which category best describes your race?	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other ❑ Decline		
Do you consider yourself Hispanic/Latino?	❑ Yes ❑ No ❑ Decline		
Preferred Language		**Alcohol:**	❑ no alcohol use ❑ alcohol use socially ❑ alcohol use daily ❑ personal history of alcoholism

	Past medical history (PLEASE CHECK OFF ALL THAT APPLY)		
❑	- No Pertinent Past Medical History	❑	Hepatitis B ❑ Hepatitis C
❑	Artificial heart valve	❑	History of staph infection
❑	Asthma ❑ Emphysema	❑	HIV ❑ AIDS ❑ Syphilis
❑	Bleeding tendency	❑	Joint problems ❑ Artificial joint
❑	Blood clot	❑	Keloids ❑ Abnormal healing
❑	Cancer (other than skin)	❑	Kidney disease
❑	Cold sores ❑ Herpes Virus	❑	Liver disease
❑	Depression ❑ Anxiety	❑	Neurologic disorder
❑	Diabetes Type I ❑ Diabetes Type II	❑	Organ Transplant
❑	Eye or vision problems	❑	Pacemaker / Defibrillator
❑	Hay fever (Seasonal Allergies)	❑	Radiation Therapy
❑	Heart Disease	❑	Stroke
❑	High Blood Pressure	❑	Thyroid Disorder
❑	High Cholesterol	❑	Other History

	Ocular History	
1	Glaucoma	❑ Yes ❑ No
2	Retinal detachment	❑ Yes ❑ No
3	Strabismus	❑ Yes ❑ No
4	Blindness	❑ Yes ❑ No
5	Macular degeneration	❑ Yes ❑ No
6	Amblyopia	❑ Yes ❑ No
7	Double vision	❑ Yes ❑ No
8	Flashes and floaters	❑ Yes ❑ No
9	Lost vision episodes	❑ Yes ❑ No
10	Halos	❑ Yes ❑ No
11	Eye pain	❑ Yes ❑ No
12	❑ Burning ❑ Dryness ❑ Itching ❑ Sandy Feeling	❑ Yes ❑ No
13	Tearing	❑ Yes ❑ No
14	Trouble Reading	❑ Yes ❑ No
15	Blurred Vision	❑ Yes ❑ No

	Ability to Heal	
1	Does your skin appear fragile, burns easily?	❑ Yes ❑ No
2	Do you form thick or raised scarring from a cut or burn?	❑ Yes ❑ No
3	Do you wax or use depilatories on your face?	❑ Yes ❑ No
4	Do you ever get cold sores?	❑ Yes ❑ No

	Past surgeries/hospitalizations		
	Surgery	Date	Notes
1			
2			
3			
4			
5			
6			

California Oculoplastics
California Retina

625 South Fair Oaks Avenue Suite 260
Pasadena, CA 91105-2667
ph: (626) 653-9395 **fx**:

Health Questionnaire

	Current medications (if none, please write none)			
	Medication Name	Dosage	# of times daily	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Preferred Pharmacy ______________________ **Phone** ______________________

Address ____
Street & Suite # City State Zip

	Allergies (if none, please write none)	
	Reaction	**Notes**
1		
2		
3		

	Family history	Affected family member	Notes
❑	- No Contributing Family History		
❑	Bleeding disorder		
❑	Heart disease		
❑	Cancer		
❑	Diabetes		
❑	Mental/emotional disorders		
❑	Any genetic diseases		

	Female Questions	
1	When was the first day of your last menstrual period?	Date:
2	Are you currently pregnant or breastfeeding?	❑ Yes ❑ No ❑ N/A

______________________ ______________________
Patient or legal guardian signature **Date**