REGISTRATION FORM

Patient Name: ____ DOB: _______/______/____________

Address: ____

City / State / Zip: ____ SSN: ________-_______-_______

Home Phone: (_____)_______-________Cell: (____)_______-________Work Phone: (____)_______-________

Sex: [ ] M [ ] F Marital Status: ______________E-Mail address:________________________________

Name of Emergency Contact:______________________ Phone:(_______)______-________ Relation:__________

Primary Care Physician / Phone: ____________________________________ / (____)________-___________

Referring Physician / Phone: ____ / (____)________-___________

Skilled Nursing Facility: [ ] Yes [ ] No Hospice: [ ] Yes [ ] No

Facility Name & Address:____

INSURANCE INFORMATION:

Primary Insurance: [ ] Yes [ ] No

Name: __________________________ Address: ____

Policy #: ________________________ Group #: _________________ Phone #: (_____)________-_________

Main Subscriber: ________________________ SSN: ________-______-______ DOB: _______/______/______

Secondary Insurance: [ ] Yes [ ] No

Name: __________________________Address: ____

Policy #: ________________________Group #: __________________Phone #: (_____)________-___________

Main Subscriber: ________________________ SSN: ________-______-______ DOB: _______/______/______

FINANCIALLY RESPONSIBLE PARTY (if different from above):

Name: ________________________________Address: ____

Relationship: ______________________ SNN: ______-______-________ DOB: _____/______/______

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payments for services rendered are due on the same day of service. As part of our services we will submit your insurance claims. Insurance/Financial arrangements should be made with our Patient Relations Dept. prior to injections, lasers, or surgeries.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARTATION:
I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:
I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.

DATE: ________/_________/_________ SIGNATURE: _________________________________

Insurance Acknowledgement

I understand that it is my responsibility to notify Retina Institute of CA of any changes to my insurance. Failure to do so may reflect a balance on my account with Retina Institute of Ca.

Patient Name: ________________________________ Date Of Birth: _______________________

Patient Signature: _____________________________ Date: _______________________________

If you have any further questions please feel free to ask the receptionist or contact our billing department at (626)574-0022

Thank You.

RetinaInstitute
On call for you

New Patient Questionnaire

NAME ______________________ DATE __________ MR# _________ AGE __________

MEDICAL HISTORY QUESTIONNAIRE – REVIEW OF SYSTEMS

Date of Birth ____________________ Date of **last eye exam** ____________________

Do you have allergies to any medications? ☐ **YES** ☐ **NO**

If YES, list the medications and reactions: ______________________________________

____

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

____

____

____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): ____________________

____

____

____

If you have ever been hospitalized, list date(s) and reason(s): ____________________________

____

____

Do you ***currently*** have any problems in the following areas?

If YES, please provide information.	YES	NO	Details
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusally tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, chest pain, exercise intolerance, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, cough -productive/blood, asthma, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.)			

RetinaInstitute
On call for you

New Patient Questionnaire

NAME ____ DATE __________ MR #_______ Date of Birth ___________

MEDICAL HISTORY QUESTIONNAIRE – REVIEW OF SYSTEMS

(continued) Do you ***currently*** have any problems in the following areas?

If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, burning, impotence, incontinence, infections, etc.)			
MUSCLES, BONES, JOINTS (muscle pain/cramps, joint pain swelling, stiffness, etc.)			
SKIN (itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.)			
NEUROLOGICAL (numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.)			
PSYCHIATRIC (depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.)			
ENDOCRINE (diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, blood disorders, leukemia, prolonged bleeding, etc.)			
ALLERGIC / IMMUNOLOGIC (recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc.)			

FAMILY HISTORY OF EYE DISEASE? YES / NO

______GLAUCOMA ______CATARACT ______RETINAL DETACHMENT ______BLINDNESS ______MACULAR DEGENERATION

______MACULAR DYSTROPHY ______RETINITIS PIGMENTOSA ______RETINAL DEGENERATION

FAMILY HISTORY OF SYSTEMIC ILLNESS? YES / NO

______DIABETES ______HYPERTENSION ______CANCER ______ARTHRITIS ______HEART DISEASE

______OTHER:

SOCIAL HISTORY? YES / NO

______SMOKING -if so, how many packs per day?____how many years?____

______ALCOHOL ______ILLICIT DRUGS

This form was completed by: ☐ *Patient* ☐ *Family* ☐ *Technician*

Signature of Technician _________________________

REVIEWED BY:

Physician's Signature ____ *Date* _________________

PHYSICIANS - 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 services 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 rights to have nay 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 bind all parties whose claims may arise out of or relate to treatment or service provided by the physician 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 of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s parties, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing 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 the 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 to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement not supplant, any other applicable statutory of common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

____

Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

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

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

By: ____ ______________________
Patient's or Patient Representative's Signature (Date)

By: ____
Print patient's Name

By: ____
(If Representative, Print Name and Relationship to Patient)

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

NOTICE OF PRIVACY PRACTICES

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our company.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However; all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment: We will use medical information to provide for your medical care. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide.
2. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
3. Payment: We will use medical information to obtain payment for the services we provide.
4. Healthcare Operations: We may use medical information to operate medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the quality and competence of our professional staff.
5. Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. We will not provide any medical information when leaving messages.
6. Sign in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

7. Email: We may contact you via email.
8. Marketing: We may contact you to give you information about products and services related to your treatment, case management, or care coordination.
9. Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. We may at times be required to disclose your health information to a law enforcement official for purposes of identifying or locating a suspect fugitive, material witness, or missing person.
10. Judicial and Administrative Proceedings: We may, and are sometimes required by law to disclose your health information in the course of administrative or judicial proceedings to the extent expressly authorized by a court or administrative order.
11. Public Health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the FDA problems with products and reactions to medications and reporting disease or infection exposure.
12. Food and Drug Administration (FDA). We may disclose health information about you (applicable to study patients only) to the FDA, or to an entity regulated by the
13. FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with Retina Institute of California via mail or email the Privacy Officer at privacyofficer@retina2020.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.