PENINSULA EYECARE MEDICAL ASSOCIATES

PATIENT REGISTRATION FORM

Please PRINT. All information must be completed. If not applicable, please mark N/A.

Name: Last, First, MI _____ Today's Date: _____

If minor, Responsible Parent Name: _____ Date of Birth: _____

Marital Status (circle one): Married / Divorced / Single / Widowed / Separated / Decline to Specify SSN#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

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

Please specify a contact preference: Do You prefer we call your home or cell number? (Circle One): ***HOME / CELL***

Email address:

_____

Would you like to receive Text Message / EMAIL reminders about upcoming appts? ***YES / NO***

Employer: _____ Occupation: _____

Primary Care Physician Name: _____ PCP Phone #: _____

Referring Physician Name (if different from above): _____ Ref Phys #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____

Insured Party's Name: _____ Insured's DOB: _____

Relationship to Insured: Self / Spouse / Child / Other _____ Insured's SSN#: _____

Secondary Insurance: _____

Insured Party's Name: _____ Insured's DOB: _____

Relationship to Insured: Self / Spouse / Child / Other _____ Insured's SSN#: _____

ROUTINE/VISION INSURANCE INFORMATION

Vision Insurance: _____

Insured Party's Name: _____ Insured's DOB: _____

Relationship to Insured: Self / Spouse / Child / Other _____ Last 4 of SSN#: _____

**** PLEASE TAKE NOTE! Medical Examinations and Treatment are not covered by ROUTINE Vision Plan Insurance. ****

I acknowledge that the information provided is complete and accurate.

X_____ _____

Patient/Designated Representative Signature Date

PENINSULA EYECARE MEDICAL ASSOCIATES

Medical History Form

Name _____ **Today's Date** _____

Describe in your own words why you are seeing us today. List any vision problems you are having:

_____

_____

Your Eye History:

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Eye Injury
☐	☐	Corneal Disease	☐	☐	Iritis
☐	☐	Crossed eyes / Lazy eye	☐	☐	Macular Degeneration
☐	☐	Glaucoma	☐	☐	Retinal Disease
☐	☐	Other eye disorders	☐	☐	Other eye Surgery
☐	☐	Cataract Surgery (Date of Surgery) Right Left			

Your Medical History:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Migraines
☐	☐	Carotid Artery Disease	☐	☐	Psychiatric / Nervous Disorder
☐	☐	Diabetes # of years	☐	☐	Rheumatoid Arthritis
☐	☐	Head or Spinal Injuries	☐	☐	Seizures, Convulsions, Fainting
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	(Women) Are you pregnant?
☐	☐	HIV	☐	☐	Other

Other Surgical History- Continue on back if more room needed. (Please include date and type).

_____

Medications: Please list medication (including eye drops) and dosage:

_____ _____

_____ _____

_____ _____

Allergies: Are you allergic to any medications, latex? YES / No If yes, please list them:

_____ _____

Family History: Has a blood relative had any of the following? If yes, indicate who as: F-Father, M- Mother, P-Paternal, M-Maternal, S-Sister, B-Brother, GF- Grandfather, Gm-Grandmother, U-Uncle, A-Aunt

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Retinal Detachment
☐	☐	Corneal Disease	☐	☐	Other Eye Problems
☐	☐	Crossed eyes / Lazy eye	☐	☐	Diabetes
☐	☐	Glaucoma	☐	☐	Heart
☐	☐	Diabetic Retinopathy	☐	☐	Stroke / Other

Bring Eye Glasses with you when you come in.
If you wear Contacts: Bring your RX/make of Contacts with you.

PENINSULA EYECARE MEDICAL ASSOCIATES

Welcome to Peninsula EyeCare Medical Associates

We are glad that you have chosen Peninsula EyeCare Medical Associates as your eye care provider. Please read the important notifications below, so that you may become familiar with our practice policies.

Please Keep your Insurance Information on File with Us Up to Date

It is the patient's responsibility to provide our office with accurate, up-to-date insurance information. Insurance companies have time limits on how long a provider can take to bill a claim. If a claim is not sent in a timely manner, it will be denied. If a claim is denied for untimely filing through no fault of our office, the charges will become the patient's responsibility.

Insurance Referrals / Authorizations

Vision Plan Authorization- our office will verify benefits and request authorization for services. Medical Plan Authorization- It is always the patient's responsibility to ensure that they have a valid referral/authorization for services rendered at each visit, if your Insurance Plan requires a referral/authorization. Should you arrive at the clinic WITHOUT a valid referral/authorization for your visit, you have the option of 1.) Contacting your insurance company from our courtesy phone to arrange an immediate referral/authorization be faxed to us or 2.) Be seen as a Self-Pay visit and filing on your own to your insurance plan or 3.) Rescheduling your appointment. Unfortunately, our clinic staff cannot contact your medical Insurance Carrier to obtain your referral/authorization for benefits.

Appointment Arrival Time

Please arrive promptly for your appointment. New patients are encouraged to arrive 20-30 minutes before their scheduled arrival time to complete initial paperwork. Patients who arrive more than 20 minutes after their appointment may be asked to reschedule.

Cancellation Fees

Kindly give 48-72 hours' notice if you are unable to keep your appointment, so that we may book another patient who needs our care in that time slot. *A $25 cancellation fee may be applied to your account if we are not informed of your cancellation/need to reschedule within **48** hours of your scheduled appointment.*

Refraction

Refractions (a test for best corrected Visual Acuity and/or a Glasses Prescription) *are not covered by Medicare or most Medical Insurance Plans*. In the absence of Routine Vision coverage, Refraction fees are the responsibility of the patient. **Refraction fees are - $55** and are subject to change.

Dilation

Please note that your eyes may be dilated during your examination. Patients may find that dilation of their pupils may blur their vision and make them sensitive to light for several hours after their examination. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected. We recommend that you bring sunglasses to each visit in our office. Please ask the checkout staff for a complimentary disposable pair if you do not have yours with you.

Pharmacy Prescriptions

You may be given a prescription for medications of medication refills in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking. Our doctors also recommend that you check with www.prescribingreference.com to become aware of all potential risks, benefits and interactions for all medications. We encourage our patients to plan ahead and notify the office at least 48 hours in advance if they require a prescription refill.

Administrative Fees / Medical Records

There is a minimal clerical charge of $50 to $75 for any administrative form the office completes. This includes disability forms, vision forms, DMV vision forms, jury service, or supplemental insurance forms. There is a minimal clerical charge for medical records that are copied in the office and/or send to another party. Legal offices seeking such records will incur additional fees. Medical Records are prepared in accordance with current California law – an administrative fee will be charged for the preparation of medical records.

PENINSULA EYECARE MEDICAL ASSOCIATES

Billing Statement Fees/Bounced Check Fees

All collection costs, attorney's fees, and court costs are the responsibility of the patient. Should a Self-Pay service not be paid in full at the time of service, a $30 billing fee will be added to the patient's account. A $5.00 per month statement fee will be added on all accounts over 30 days past due, to the fullest extent allowed by law. Should we incur a bounced check from our bank, we will pass that on to you as well as an administrative fee of $35.

Medical Examinations and Treatment vs Vision Plan (Routine) Examinations

The reason for your appointment determines whether the appointment is filed to your Vision Insurance or your Medical Insurance. When sending a claim to the patients' medical insurance company, our records will indicate that the patient was seen for a medical reason and has received a medical diagnosis. When sending a claim to the patient's routine vision insurance plan, the claim will indicate that the patient was seen for a routine eye exam. Our office will NOT send medical visit claims to a vision insurance plan under a "routine" diagnosis. We cannot change the diagnosis on a claim in order to receive payment. All diagnosis must be documented in the patient's chart at the date of service in order to be included on a claim.

Insurance Assignment and Release

I certify that I have insurance coverage with the company(ies) I provided and assign directly to Julie Madani-Becker, MD, Darren K Knight, MD, Crystal Kim, OD, Alaina Liu, OD and Peninsula EyeCare Medical Associates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. The above medical group may use my health care information and may disclose such information to the above-mentioned insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits and the benefits payable for related services.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Peninsula EyeCare Medical for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Copay, Deductibles, and Non-Covered Services

I acknowledge that I am financially responsible for copays, deductibles and non-covered services, and that those amounts will be collected at the time of service.

Billing and Collections

I acknowledge that Peninsula EyeCare Medical is providing services in good faith, and that it will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interest, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Peninsula EyeCare Medical with updated billing and insurance information on each and every visit.

By signing below, I understand and agree to the above Peninsula EyeCare Medical Associates Financial Policies.

X_____ **X**_____

Patient/Designated Representative Signature Today's Date

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HIPAA Protected Health Information Acknowledgement

Peninsula EyeCare Medical Associates follows HIPAA guidelines in regard to how we handle your PHI (Protected Health Information). Copies of our Notice of Privacy Practices are available at the front desk. By signing below, you acknowledge that you have read and agree to our Notice of Privacy Practices. Please list any individuals or groups you wish to grant access to your Protected Health Information and any limitations to their access here:

Name:_____Phone:_____Relationship:_____

All info will be shared unless otherwise specified here: _____.

**You may amend or revoke the rights to your protected health information any time, by submitting a request to Peninsula EyeCare Medical Associates in writing.*

I acknowledge that I have been provided with Peninsula EyeCare Medical Associates Notice of Privacy Practices Policies.

X_____ **X**_____

Name of Patient Date of Birth

X_____ **X**_____

Patient/Designated Representative *Signature* Today's Date