Insurance Cards Copied ❑ Doctor: _____ Date: _____ Account: _____

NEW PATIENT INFORMATION (Please Print Legibly and Complete All Sections)

PATIENT PERSONAL INFORMATION Marital Status: _____ Sex: ____

Name: _____ _____ _____
(Last) (First) (MI)

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

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Date of Birth: _____ / _____ / _____ Driver Lic. #: _____ SSN: _____ - _____ - _____

School/Employer: _____ E-Mail: _____

Spouse Name: _____ _____ _____
(Last) (First) (MI)

Address (if different): _____ City:_____ State: _____ Zip:____

GUARANTOR INFORMATION

Mother's Name: _____Work (_____) _____ - _____ Cell (_____) _____ - _____

Address (if different): _____ City:_____ State: _____ Zip:____

Date of Birth: _____ / _____ / _____ Driver Lic. #: _____ SSN: _____ - _____ - _____

Father's Name: _____Work (_____) _____ - _____ Cell (_____) _____ - _____

Address (if different): _____ City:_____ State: _____ Zip:_____

Date of Birth: _____ / _____ / _____ Driver Lic. #: _____ SSN: _____ - _____ - _____

REFERRAL INFORMATION

Referred by: _____ Name of Primary Medical Doctor: _____

Name(s) of Other Physician(s) who care for Patient: _____

EMERGENCY CONTACT

Name of Person Not Living with You: _____ Relationship: _____

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

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance Company: _____

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

Name of Insured: _____ Date of Birth: ___ / ____ / _____ Relationship: _____

Insurance Number: _____ Group Number: _____SSN: _____ - _____ - _____

Secondary Insurance Company: _____

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

Name of Insured: _____ Date of Birth: ___ / ____ / _____ Relationship: _____

Insurance Number: _____ Group Number: _____SSN: _____ - _____ - _____

Check if Applicable: ❑ Retiree Coverage

Financial Agreement and Authorization for Treatment

I authorize treatment of the patient by a licensed physician or whom he/she may designate at the office of the Family Eye Medical Group. It is understood that an eye examination carries a degree of risk. I authorize photographs for scientific or medical purposes and agree to their use for purposes deemed necessary for scientific use such as teaching, publication, or research. It is clearly understood that photographs will not be shown to the lay public or other patients. I authorize the release of any information for scientific or medical purposes regarding medical conditions when under observation or treatment, including history, findings, x-ray readings, diagnoses, photographic studies, and subsequent or future developments. Initial: ____

I agree that I may be contacted electronically. I agree to pay all charges shown by statements, promptly upon presentation. In the event of non-payment by my insurance plan(s), I agree to pay all non-covered and/or deductibles as determined by my health plan(s) in conjunction with the policy of Family Eye Medical Group. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all the proceeds of insurance are assigned to the office where applicable, but without the office assuming responsibility for the collection. I authorize the release of medical information to insurance carriers concerning my illness and treatments and irrevocably assign to the doctor all payments for medical services provided to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. A photocopy is as valid and effective as the original. Initial: ____

Signature of Financially Responsible Person: _____ Date: ___ / ____ / _____

Notification of Privacy Practices

I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature of Patient or Guardian: _____ Date: ___ / ____ / _____

Advance Beneficiary Notice

Physician Notice: Many insurance carriers do not pay for "refraction" (the determination of the need for eyeglasses or contact lenses to correct vision). Authorization to perform the procedure does not guarantee payment. It only authorizes us to perform the service. The insurance will only pay if it determines that a refraction is a covered benefit of your particular policy. If the insurance denies payment, we must bill the patient for this service: Procedure Code: 92015 **Charge: $45.00**

Beneficiary Agreement: I have been notified by my physician that he/she believes that, in my case, my insurance is likely to deny payment for the service(s) identified above, for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Signature of Patient or Guardian: _____ Date: ___ / ____ / _____

Contact Lens Fitting Policy

A contact lens fitting or refitting fee is applied to patients who elect to be fit or refit with contact lenses. Insurance companies generally do not cover this fee. This fee is not included in the refraction and does not include the actual contact lenses. These charges will be discussed at the time of service. If you elect to have this service done, a contact lens agreement will be provided.

Signature of Patient or Guardian: _____ Date: ___ / ____ / _____

Minor Consent for Care

In my absence, I authorize _____ to bring my child for ophthalmic care (valid for one year).

Signature of Patient or Guardian: _____ Date: ___ / ____ / _____

FAMILY EYE MEDICAL GROUP
4100 Long Beach Boulevard, Suite 108
Long Beach, California 90807-2696
Tel: (562) 426-3925 · Fax: (562) 595-7639

Office Policy on Appointments

ADULT STRABISMUS/ PEDIATRIC OPHTHALMOLOGY:
(562) 426-3925
Andrew E. Choy, M.D.
Teresa O. Rosales, M.D.
Robert A. Clark, M.D.
Ajay Manchandia, M.D.

COMPREHENSIVE OPHTHALMOLOGY:
(562) 426-3925
Robert A. Clark, M.D.
Ajay Manchandia, M.D.

CONTACT LENSES/OPTICAL
(562) 426-3925, Ext.156

ORBIT & OCULOPLASTICS:
(562) 426-3925
Andrew E. Choy, M.D.

INSURANCE SECTION
(562) 426-7674

SURGERY SECTION
(562) 426-3925, Ext.133

Appointments have a 10-minute grace period. If the appointment has not been canceled and the patient has not checked in by the end of the grace period, the appointment is considered missed. There will be a $25 fee to reschedule your appointment.

Fee to reschedule a missed appointment: $25.00

Signature: _____ Date: _____

Today's Date: / / Family Eye Medical Group

Patient History Questionnaire (Update Each Visit)

Patient Name: _____ Date of Birth: / / Occupation: _____

How is the patient's general health (check one)? ❑ Good ❑ Fair ❑ Poor

Does the patient have problems with the following bodily systems (check all that apply)?

❑ Eyes ❑ Gastrointestinal ❑ Blood, Lymph System ❑ Fever, Weight Loss

❑ Genitourinary ❑ Allergic/Immunologic ❑ Ears/Nose/Mouth/Throat ❑ Skin, Breast

❑ Psychiatric ❑ Cardiovascular ❑ Neurologic ❑ Diabetes, Thyroid

❑ Respiratory ❑ Musculoskeletal

Please explain checked items: (use back if needed)

Does the patient have (check appropriate box, use back if needed):

Allergy to Medicines? ❑ yes ❑ no If yes, list medicines/reactions: _____

Diabetes? ❑ yes ❑ no If yes, type and date of diagnosis: _____

Other Allergies? ❑ yes ❑ no If yes, describe allergy/reaction: _____

Headaches? ❑ yes ❑ no Immunizations Up to Date? ❑ yes ❑ no

Surgeries (Not to Eye)? ❑ yes ❑ no Describe: _____

Other Health Problems? ❑ yes ❑ no Describe: _____

Does the patient use (check appropriate box):

Cigarettes/Tobacco? ❑ yes ❑ no Alcohol? ❑ yes ❑ no Other Substances? ❑ yes ❑ no

List Current Medications:_____

Name of Family Doctor: Date of Last Visit: / /

Is there a family history of (check all that apply):

❑ High Blood Pressure ❑ Diabetes ❑ Glaucoma ❑ Cataracts

❑ Macular Degeneration ❑ Retinal Detachments ❑ Other Eye Conditions

Please explain checked items and relation to patient:

Does the patient have any of the following eye history (check appropriate box, use back if needed):

Eye Surgeries? ❑ yes ❑ no Date/Describe: _____

Eye Injuries? ❑ yes ❑ no Date/Describe: _____

Other Eye Problems? ❑ yes ❑ no Describe: _____

Glasses? ❑ yes ❑ no Contact Lenses? ❑ yes ❑ no Type: _____

Glaucoma? ❑ yes ❑ no Cataracts? ❑ yes ❑ no

Dry Eyes? ❑ yes ❑ no Blurred Vision? ❑ yes ❑ no

Special Visual Needs/Difficulties:

Office Use: Date Updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Use this space to expand upon answers from page 1.

FAMILY EYE MEDICAL GROUP
4100 Long Beach Boulevard, #108
Long Beach, California 90807-2696
Tel: (562)426-3925; Fax: (562)595-7639

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on September 25, 2017 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

a. Keep your medical information private.
b. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
c. Follow the terms of the notice that is now in effect.

We Have the Right to:

a. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
b. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

a. FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
b. FOR PAYMENT: We may disclose your medical information for payment purposes.
c. FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

4. ADDITIONAL USES AND DISCLOSURE: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

a. EDUCATION: Medical information with a public or private organization or person who can legally assist in educational efforts.
b. NOTIFICATION: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
c. DISASTER RELIEF: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.
d. RESEARCH IN LIMITED CIRCUMSTANCES: Medical information for research purposes in limited circumstances where the research was approved by a review board that reviewed the research proposal and established protocols to ensure privacy of medical information.
e. FUNERAL DIRECTOR, CORONER, MEDICAL EXAMINER: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
f. SPECIALIZED GOVERNMENT FUNCTIONS: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
g. COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain Circumstances.
h. PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to people subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
i. VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help

law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

j. WORKERS COMPENSATION: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar program.
k. LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials, These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes emergencies.

5. YOUR INDIVIDUAL RIGHTS

a. You may look at or get copies of your medical information. You may request that we provide photocopies. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $1 for each page and we will charge postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
b. You may receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
c. You may request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
d. You may restrict certain disclosures of your medical information to health plans/ insurance companies if the you pay out of pocket in full for the health care service.
e. You must authorize the release of your information for any marketing or fundraising activity and for any sale of any of your information.
f. You must authorize the release of genetic information for health insurance underwriting.
g. You must be notified about any breach of unsecured medical information.
h. You may request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
i. You may request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. QUESTIONS AND COMPLAINTS: If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Contact Person: The President of Family Eye Medical Group, telephone (562)426-3925.