RETINAL CONSULTANTS OF SOUTHERN CALIFORNIA
MEDICAL GROUP, INC. **DATE**_____
Please Print

NAME_____ **SEX**: **M** **F**
Last **First** **MI**
HOME ADDRESS _____
Street **City** **State** **Zip**
HOME PHONE( )_____**BUSINESS PHONE( )**_____

DATE OF BIRTH_____/_____/_____ **AGE** _____ **CELL PHONE( )**_____

SOCIAL SECURITY NUMBER:_____**DRIVER'S LICENSE #**_____

OCCUPATION_____**E-MAIL**_____

EMPLOYER'S NAME_____**EMPLOYER'S ADDRESS**_____

SPOUSE/PARENT'S NAME_____**SPOUSE/PARENT'S EMPLOYER**_____

IN CASE OF EMERGENCY CONTACT:

NAME_____ **RELATIONSHIP**_____

HOME PHONE( )_____ **BUSINESS PHONE**( )_____

WHO REFERRED YOU TO US?_____**PHONE NUMBER**_____

NAME & ADDRESS OF FAMILY DOCTOR OR INTERNIST_____

_____**PHONE NUMBER ( )**_____

MEDICAL INFORMATION: Please fill out so we may get as complete a medical history as possible.

1. Have you ever had any eye diseases (e.g., Glaucoma, cataract, macular degeneration, retinal detachment)? No
If yes, please explain_____

2. Have you ever had any medical conditions diagnosed (e.g., Diabetes, high blood pressure, cancer)? No
If yes, please explain_____

3. Have you ever been hospitalized? No
If yes, please explain_____

4. Have you ever had eye surgery or eye laser? No
If yes, please explain_____

5. Have you ever had any other surgery? No
If yes, please explain_____

6. Do you take any eye medications or *other medications*? No
If yes, please list_____
_____

7. Do you have any drug allergies? No
If yes, please list_____

8. Do any eye diseases or medical problems run in your family (e.g., Macular degeneration, diabetes)? No
If yes, please explain_____

Retinal Consultants of So. CA Medical Group

SHOULD ANY OF MY INSURANCE INFORMATION BE INCORRECT OR INVALID I WILL ASSUME RESPONSIBILITY IN FULL FOR ANY AND ALL CHARGES INCURRED.

I AUTHORIZE AND REQUEST THAT PAYMENTS UNDER MY MEDICAL INSURANCE PROGRAM BE MADE DIRECTLY TO DR. DIDDIE, RETINAL CONSULTANTS OF SO. CA, FOR ANY SERVICE FURNISHED TO ME. I ALSO AUTHORIZE DR. DIDDIE TO RELEASE ANY INFORMATION NEEDED FOR PAYMENT OF CLAIMS. I FURTHER PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

*I UNDERSTAND THAT MY EYES WILL BE DILATED AT EACH EXAM AND THAT SINCE DILATING DROPS CAN CREATE A VISUAL DISTURBANCE, THE ASSISTANCE OF SOMEONE ELSE FOR TRANSPORTATION IS RECOMMENDED. VISION WILL BE MORE BLURRED AFTER LASER TREATMENTS AND OTHER PROCEDURES.

X_____

PATIENT OR RESPONSIBLE PARTY

_____

DATE

PLEASE RETURN THESE FORMS TO THE RECEPTIONIST WITH YOUR INSURANCE CARDS.

Retinal Consultants of So. CA Medical Group

TO OUR VALUED PATIENTS:

We are committed to providing you with the highest quality ophthalmic care possible. The changes associated with the Affordable Care Act have resulted in many patients shouldering increased cost through higher deductibles, copay and coinsurance amounts. This has caused more administrative work for our office staff and some unpleasant surprises for patients. To streamline the process and to make sure that you understand your payment responsibilities we would appreciate you reading and initialing our policies below. Thank you for your understanding.

_____PAYMENT AT TIME OF SERVICE: Copayments and unmet deductibles are due at the time of service at check-in. Co-insurance (what the insurance company doesn't pay) is due upon receipt of statement. We accept cash, checks and MasterCard and Visa.

_____INSURED PATIENTS: We have made prior arrangements with many insurers to accept an Assignment of Benefits. As a courtesy we will continue to bill those plans with whom we participate and will only require you to pay the authorized copayments and unpaid balance.

_____SELF-PAY PATIENTS: In order to address the needs of our patients without insurance with which we are contracted, we offer a discounted fee for payment at the time of service. This discount acknowledges the lower cost involved in billing, when a claim does not need to be submitted to an insurance company. In order to qualify, payments need to be made in full on completion of your visit, or prior to a procedure. Any unpaid balance is not eligible for a discount. This discount applies to all provided services and IS OFFERED ONLY AT THE TIME OF SERVICE.

_____There will be a $20 administrative fee for copying medical records.

BY SIGNING BELOW, YOU AGREE TO THE ABOVE TERMS.

PATIENT NAME _____ DATE_____
Printed

PATIENT or RESPONSIBLE PARTY SIGNATURE_____

SUMMARY OF PRIVACY PRACTICES
FOR
RETINAL CONSULTANTS OF SOUTHERN CALIFORNIA MEDICAL GROUP, INC.

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice is available upon request.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that is available upon request):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient call reminders
- To run our practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For accurate medical records keeping and correspondence to referring physicians
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with Retinal Consultants or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our office. All complaints must be submitted in writing.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices available on request.

I have received a copy of this Privacy Practices Summary and understand that upon request I may obtain a detailed copy.

X_____ Date _____