AMERICAN EYE INSTITUTE, A Medical Corporation

6330 San Vicente Blvd. Suite 408 Los Angeles, CA 90048
310 652-1133 Tax ID 95-4597348

Barak Maguen, MD/ Anthony Nesburn MD/ Ezra Maguen, MD/ Kristin Nesburn, MD/ Kenneth L. Gordon, MD/ Aaron Savar, MD

E-Mail: _____ Today's Date:_____

Patient Name: _____

Last First MI

Home Address: _____ City: _____

State: _____ Zip: _____ Phone _____ Ok to leave message? Y/N

SS# _____ Driver's License: _____ State: _____

DOB: _____ Gender at birth: M/F Marital Status: Single Married Other

If pt. is a minor, Name of parent/guardian: _____ Relationship: _____

Employer's Name: _____ Occupation: _____

Business Address: _____

Business Phone: _____

Referred By: _____

Primary Physician: _____ Phone: _____

Emergency Contact 1 : _____ Phone: _____

Emergency Contact 2: _____ Phone: _____

Subscriber of Insurance: _____ DOB: _____

Relationship to patient: _____ Last 4 digits of SS# _____

MEDICAL HISTORY

Current medications (Rx or over the counter) _____

_____

_____

Allergies to medications? **Y/N** _____

Date of last EYE EXAM? _____

List major illnesses or Injuries:_____

List previous surgeries:_____

Do you wear glasses? **Y/N** Contact lenses? **Y/N** Type? _____

Please circle any problems you have below:

EYES: poor vision, eye pain, tearing, redness, droopy lids, other?
GENERAL: fever, fatigue, other?
Ears, Nose, Throat: hearing loss, earache, dry mouth, stuffy nose, other?
Cardiovascular: heart disease, high BP, other?
Respiratory: Short of breath, asthma, emphysema, other?
Gastrointestinal: ulcers, liver disease, other?
Genital, Kidney, Bladder?
Are you **pregnant**? Y/N
Muscles, Bones, Joints: pain, stiffness, arthritis?
Skin: rash, hives, eczema, acne, other?
Neurological: numbness, headache, migraines, seizures, other?
Psychiatric: anxiety, depression, other?
Endocrine: diabetes, thyroid disease, other?
Blood/Lymph: cholesterol, anemia, other?
Allergy: swelling, itching, sneezing, other?
Immunologic: Lupus, RA, MS, other?

FAMILY HISTORY

Have your parents, grandparents, or siblings had: (Circle all that apply) Blindness, Cataracts, Glaucoma, Diabetes, Cancer, Thyroid Disease, Heart Disease, Stroke, Arthritis? **Y/N** Unknown

SOCIAL HISTORY

Does your vision limit any activities of daily life? **Y/N**
(Circle all that apply) driving, reading, sports, work, other?
Do you use tobacco? Y/N Alcohol? Y/N Substances? Y/N How much? _____

PLEASE READ THE FOLLOWING:

1. Without Insurance: **Payment is due at time of service**.

2. Insurance: We are happy to bill your plan AS A COURTESY but **you are responsible for deductibles, co-payments, and non-covered charges at the TIME OF SERVICE.**

3. You are ultimately responsible for payment in full of all services rendered. **Non paid accounts are referred to a collection agency 90 days after receipt of first billing statement**. Please pay your bills on time.

4. Please understand what your policy covers. If you have an **HMO, or managed care plan, you are responsible for obtaining AUTHORIZATION for every visit. Without authorization, you will be responsible for payment.**

5. Cancellation Fee is $40 if we are not given 24 hours notice.

6. **REFRACTION:** Medicare and most medical insurances do not pay for this part of your exam. It is considered an out-of-pocket expense. Our fee for a REFRACTION is $85. Some patients have a separate vision plan similar to a dental plan. Please let us know BEFORE your exam if you have a separate vision plan. It really helps.

7. **CONTACT LENS FITTINGS and CONTACT LENSES are not a medically covered service**. Fees for contact lens fitting exams and corneal readings are collected at the time of service. Contact lenses range depending on the curvature of your cornea as well as other factors. There is no "one size fits all" with contact lenses. If you have a vision plan that covers a portion of this service. Please let us know PRIOR to your exam if you have this benefit. Thank you!

8. **Medical Records**: Pursuant to Health & Safety Code section 123110 a doctor can charge 25 cents per page plus a reasonable clerical fee.

9. If you wish to use your **POINT OF SERVICE BENEFIT**, please initial here: _____

10. I have been offered a copy of Notice of Privacy Practices/HIPAA.

I understand the above policies of American Eye Institute. I hereby authorize my doctor at American Eye Institute, to furnish my insurance carrier all information which the insurance company may request concerning my present illness or injury. I understand that it is my financial responsibility to pay for non-covered and unpaid services. I understand that my doctor at American Eye Institute accepts Medicare assignment, meaning that Medicare determines the usual and customary fee for services rendered.
I request that payment of authorized benefits be made directly to my provider at American Eye Institute, TAX ID 95-4597348 on my behalf.

_____

Patient's Signature (Or parent or guardian if a minor) Date

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contractual agreement 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 contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services 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. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date: _____ Patient's Initials: _____

ARTICLE 7: I have read and understand all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

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.

NOTICE: BY SIGNING THIS CONTRACTUAL AGREEMENT YOU ARE AGREEING TO HAVE ANY 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 AGREEMENT.

_____ Dated: _____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

I agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ Dated: _____

(Physician or Duly-Authorized Representative)

_____ _____

Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

Poster Compliance Center
SINCE 1991

HIPAA Privacy Notice
(Health Insurance Portability & Accountability Act)

Your Privacy is Important to Us

We value our relationship with you. We respect your right to privacy and we do everything we can to protect the information provided to us on behalf of our customers and our employees. We ask all employees to follow our policies and procedures about customer privacy and information sharing.

We Protect Our Customer's Privacy:

- We restrict access to electronic customer information by using protected passwords when using company information systems.
- We do not leave customer information open or in view at workstations when our employees are not there. We lock up all of our customer files before leaving the workplace.
- We share customer information only with employees as needed to complete service to the customer.

We Protect Our Employee's Privacy:

- Your personal information is only shared with those administering our company health benefits, financial services, or management programs on behalf of all our employees.
- You are exposed to confidential customer information only as it is necessary to provide service to the customer.
- We provide you with required communications about access to your health rights under COBRA (continuation of health coverage) and HIPAA (portability of health coverage and privacy of health information) guidelines.

Your Personal Health Information Rights Are Protected

The Health Insurance Portability and Accountability Act of 1996 helps to protect your rights to health coverage during events such as changing or losing jobs, pregnancy, moving, or divorce, and provides rights and protections for employers when getting and renewing health coverage for their employees. It also covers your rights with respect to protected health information.

"Protected health information" includes any individually identifiable information that is transmitted or maintained in any form or medium that relates to the past, present, or future physical or mental health condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.

- You have the right to access, inspect and obtain a copy of your protected health information.
- You have the right to amend your protected health information.
- You have the right to request restrictions on uses and disclosures of your protected health information.
- You have a right to an explanation of the legal duties and privacy practices of those who have your protected health information.
- You have the right to receive confidential communications regarding your protected health information.
- You have the right to receive an accounting of disclosures of your protected health information.
- You have a right to file a formal, written complaint with those who have your protected health information, or with the Department of Health & Human Services, if you feel your privacy rights have been violated. You may not be retaliated against for filing a complaint.

These privacy rules are assured under HIPAA (Health Insurance Portability & Accountability Act of 1996) and are enforced by the US Department of Health & Human Services Office of Civil Rights.

US Department of Health & Human Services
Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201
(877) 696-6775.