Advanced Eye Health & Surgical Care
554 E. San Bernardino Road, Ste. 102
Covina, CA 91723
626-332-1888
626-332-1808
www.omnieyecare.com

NEW PATIENT CONSULTATION

Please bring all the following to your appointment along with the forms completed and signed.

- ☐ List of your current medications and allergies
- ☐ Insurance Cards and Vision Insurance Information
- ☐ Primary Doctor Referral (if required by your insurance company)
- ☐ Your co-payment (if applicable)
- ☐ Any glasses you are currently using
- ☐ Previous vision exam or visual field test reports (optional)
- ☐ **Do not** wear your contact lenses if possible. Bring the box or extra contacts in the original packaging if you have them or your current prescription. Please bring your contact lens case if you need to wear your contact lenses to the office and take them out upon arrival.

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TODAY'S DATE: _______________

PATIENT: ____
LAST NAME FIRST NAME MIDDLE INITIAL

HOME PHONE: (____) _____ - _______ MOBILE PHONE: (____) _____ - _______ WORK PHONE: (____) _____ - _______

ADDRESS: ____ APT #: ____________________

CITY, STATE, ZIP: ____

E-MAIL ADDRESS: ____

SEX: ______________ MARITAL STATUS: ______________________ PRIOR NAME: ____________________________

PATIENT'S SOCIAL SECURITY NO.: _____________________ DATE OF BIRTH: ___________________ AGE: ________

DO YOU AUTHORIZE RELEASE OF PERSONAL INFORMATION? YES ________ NO ________

GUARANTOR PERSONS NAME (PERSON FINANCIALLY RESPONSIBLE): _______________________________________

RELATIONSHIP TO PATIENT: __________________PHONE #: _______________________ DATE OF BIRTH: __________

HOW DID YOU HEAR ABOUT US? DOCTOR ____ FRIEND ____ INSURANCE ____ PHONE BOOK/ONLINE ____

PRIMARY INSURANCE COMPANY ____

ID # ____

SECONDARY INSURANCE COMPANY ____

ID # ____

MEDICARE#________________ MEDI-CAL#______________ ARE YOU A MEMBER OF HMO? YES____ NO ____

WHICH ONE? ________________________________ MEDICAL GROUP: __________________________________

NAME OF EMPLOYER: __________________________________ OCCUPATION: ____________________________

EMPLOYER'S ADDRESS: ________________________________ EMPLOYER'S PHONE #: _______________________

IS THIS A WORKERS' COMPENSATION? YES_____ NO _____

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME: ____ TELEPHONE: ____________________________

RELATIONSHIP TO PATIENT: ____

NAME OF SPOUSE/PARENT OR GUARDIAN IF PATIENT IS A MINOR: _________________________________

ADDRESS OF PARENT OR GUARDIAN: ____

CITY, STATE, ZIP: ____

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PATIENT MEDICAL HISTORY & REVIEW OF SYSTEMS

PATIENT NAME: ______________________________ DOB: ____________________

Medical Problems:____

____

____

PAST OCULAR HISTORY

Check all that apply	*YES*	*NO*
Glaucoma		
Cataract		
Macular Degenartion		
Diabetic Eye Disease		
Trauma		
Retinal Detachment		
Lazy Eye		
Lazer Treatment		
Eye Surgery		
If so, type:		

FAMILY OCULAR HISTORY

Check all that apply	*YES*	*NO*
Glaucoma		
Cataract		
Macular Degenration		
Retinal Detachment		
Other:		

SOCIAL HISTORY

Smoking	Yes	No
If yes:	packs/day	/years
Alcohol	Yes	No
○Social	○ Occasional	○Heavy
	Drinks/day	/years

CURRENT MEDICATIONS, DOSE & FREQUENCY

Right eye: ______________________________

____

____

Left eye: ______________________________

____

____

MAJOR SURGERY OR HOSPITALIZATION NOT LISTED ABOVE:

____

____

____

DRUG ALLERGIES:______________________________

____

____

CURRENT MEDICATIONS:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Reviewed with patient: ______________________________

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PATIENT MEDICAL HISTORY & REVIEW OF SYSTEMS

PATIENT NAME: ______________________________ DOB: ______________________

Please circle yes or no (Y or N) for each question and write in essential information:

CONSTITUTIONAL		
Flu	Y	N
Fever	Y	N
Fatigue	Y	N
Headache	Y	N
Recent weight change	Y	N
EAR, NOSE, THROAT		
Hearing problems	Y	N
Sinus	Y	N
Throat	Y	N
CARDIOVASCULAR		
Chest pain	Y	N
Palpitations	Y	N
High blood pressure	Y	N
Heart failure	Y	N
Pacemaker	Y	N
Heart attack	Y	N
Angioplasty/bypass	Y	N
Valve disease	Y	N
Carotid artery disease	Y	N
RESPIRATORY		
Shortness of breath	Y	N
Asthma	Y	N
Emphysema	Y	N
Cough	Y	N
Bronchitis	Y	N
Pneumonia	Y	N
Tuberculosis	Y	N
GASTROINTESTINAL		
Heartburn	Y	N
Bowel problems	Y	N
Hepatitis	Y	N
Hepatitis	Y	N
Inflamed bowel disease	Y	N
SKIN		
Rash	Y	N
Itch	Y	N
Lesions	Y	N
Growth/Tumors	Y	N

MUSCULOSKELETAL (CONT.)		
Joint pain	Y	N
Back pain	Y	N
Fractures	Y	N
Marfan's syndrome	Y	N
Ankylosing spondylitis	Y	N
NEUROLOGICAL		
Stroke	Y	N
Weakness	Y	N
Seizures	Y	N
Multiple sclerosis	Y	N
HEMATOLOGIC		
Anemia	Y	N
Sickle cell	Y	N
Bleeding abnormality	Y	N
Elevated cholesterol	Y	N
IMMUNOLOGY		
Immune deficiency	Y	N
Lupus	Y	N
Sjogren's	Y	N
Other	Y	N
PSYCHIATRIC		
Dementia	Y	N
Alzheimer's	Y	N
Depression	Y	N
Anxiety	Y	N
Schizophrenia	Y	N
GENITOURINARY		
Prostate	Y	N
Kidney stones	Y	N
Hysterectomy	Y	N
Pregnant	Y	N
ENDOCRINE		
Thyroid	Y	N
Diabetes	Y	N
If yes, years:		
Last blood sugar(A1C):		
Other:		

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FINANCIAL POLICY

Thank you for choosing Omni Eye Care as your healthcare provider. We are committed to your treatment being a successful experience. Our Medical and Business Office staff members will work hard to make sure your paperwork is filed accurately and promptly.

WE ACCEPT MASTERCARD, VISA, CHECKS AND CASH.

Insurance & Insurance Collection:

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Our billing staff has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which they pay. Please **initial** next to your category of insurance listed below, as this will help us to speed up payment and eliminate any confusion in the future. Thank you.

Non-Contracted / Indemnity Insurance Plans :
We will bill your insurance company as a courtesy. Our office, as a convenience and a service to you, will absorb the costs incurred for billing. We require you to pay in full at the time of service. Your insurance company will send payment directly to you.

Plans in which we are participating providers:
HMO PLANS. All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral information and authorizations in advance of your appointment. You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

PPO PLANS. We have agreed to accept the discounted rate from your plan, however all co-insurance is your responsibility. We will estimate balances to the best of our ability.

Self-Insured/Union Plans:
This office has been thoroughly trained on how to get reimbursed by your employer; however, in the event there is a problem, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file complaint letters to the Department of Labor and your administrator if necessary.

Medicare:
As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance and we must collect it. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

Secondary Insurers:
Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Co-payments, co-insurance and patient deductibles:
All co-payments, deductibles, share of costs and coinsurances are due at the time of service.

Services not Covered by your Insurance:
Services not covered by your insurance are payable in full prior to or at the time-of-service. We will try to provide prior notification if you are going to receive a service that we know is not or may not be covered by your insurance. Some of these services may include refractions, refractive surgery, and premium intraocular lenses with cataract surgery.

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Initials

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FINANCIAL POLICY (CONTINUED)

Missed Appointments:
There is a $35 missed appointment fee if you cancel or reschedule a clinic visit appointment with less than 24 hours advance notice or if you fail to arrive for your appointment.

Minor Patients:
The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

About your information:
We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you.

We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable. Our goal at Omni Eye Care is to serve your medical needs as well as we possibly can; and we want to make the billing a non-issue right from the start.

Forms:
There is no charge for forms completed as part of an office visit. There will be a charge for filling out forms based on your medical records when it is not done at the time of an appointment. Fees vary depending upon the form, including school forms, child care forms, immunization cards, disability forms, etc.

Records and Copying:
There will be a $25 charge for copying materials from your chart when done other than at the time of a visit including the transfer of records to another facility.

Returned Check Fee:
There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

______________________________________ ____________________
Signature of Patient or Responsible Party Date

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AGREEMENT OF RESPONSIBILITY

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _____________________

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: _____________________

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have reviewed Notice of California Privacy Practices as visibility posted at offices of Omni Eye Care. I also acknowledge I am entitled to receive a copy from the office staff.

Initial: _____________________

Release of Information/Assignment of Benefits

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: ____ Date: ______________________________

Signature: ____

Legal Guardian (if Minor): ____________________________________

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ARBITRATION AGREEMENT AND INFORMED CONSENT

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 state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any 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 also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider.s clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider.s associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

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 thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party for such party.s own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that 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 the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover noneconomic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that arbitration rules within the State of California shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: 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 legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. ________. Effective as the date of first professional services. If any provision of the 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 OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Print Name: ____ Date: ________________________

Patient Signature: ***X*** ____
(Or patient Representative) (Indicate relationship if signing for patient)