NEW PATIENT REGISTRATION FORM

P R I N T C L E A R L Y

Patient Name: ____________________ **Sex:** (circle) **M/F Age:** ______

DOB: ______________ **SS#** ______________________ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow**

Address ____________________ **City** ______________ **State:** _______ **ZIP** _______

Home Phone ____________________ **Cell** ____________________

Preferred contact number: ☐ ***home*** ☐ ***cell***

Email ____

Patient Occupation/Employer ____

Work Address ____

Who referred you to our office? ____

Primary Care Physician: ____

Pharmacy ____________________ **Pharmacy number** ____________________

I N S U R A N C E I N F O R M A T I O N

My Insurance is a: ☐**PPO** ☐**HMO** ☐**POS** ☐**Other** ____________________

Patient's relationship to responsible party: ☐**self** ☐**spouse** ☐**child** ☐**guardian** ☐**other**

Primary Insurance ____________________ **Member ID#** ____________________

Name of Insured ____________________ **DOB** ____________________

Secondary Insurance ____________________ **Member ID#** ____________________

Name of Insured ____________________ **DOB** ____________________

DO YOU HAVE VISION INSURANCE: ☐ Yes ☐ No

Member ID ____________________ **DOB** ____________ **SS#** ____________________

AUTHORIZATION- EMAIL CONSENT AND PRIVACY NOTIFICATION (HIPAA)

I authorize treatment and assignment of medical benefits to Dr. Nadji. I have an opportunity to review Dr. Nadji's HIPAA policy and email consent, and I agree to receive e-mail communication. Accounts 30 days past due are subject to 12% interest per annum. Administration fee of $50.00 may be applied for appointments changed within 24 hours.

SIGNED: ____ **DATE:** ____________________

Rev. 08/03/2018

E. Joseph Nadji, M.D. Inc &, .Michael Reynard, M.D.

1301 – 20th Street #260   Santa Monica, CA 90404

Dear New Patient or Established Patient,

We would like to make you aware of our office policies.

Your chart information will be maintained under strict privacy in accordance with HIPAA (Health Information Privacy Act). If you object to signing your name on the sign-in sheet, please initial the form and tell the receptionist who you are.

Traditional medical insurance does not cover basic refraction for eyeglass prescriptions nor fitting and refraction for contact lenses. The additional fee for refraction is $100, for contact lens update it is $150, for contact lens fitting it is $175, and for contact lens training it is $125. Payments for these uncovered services are due at the time of service. You may have a separate vision plan that covers refraction and/or eyeglasses. If so please tell us since we do not do retroactive billing. In addition, we are extremely careful when handling patient's frames yet we are not liable for any damages that may occur to your frames during the visit. Any frames left with the optician for new lenses carries the risk of being damaged during processing. The office is not responsible in the event the lab damages the frames during placement of new lenses.

The charge for completing a DMV report, or a disability form, or a brief insurance report is $45. There is a minimal clerical charge of $45 for medical records that are copies and/or sent to another party. All appointments rescheduled within 24 hours are subject to a $45 cancellation fee that may be immediately charged to your credit card on file.

Please be aware that we are not allowed to waive deductibles or co-payments; these are due at the time of service. Copayments not made at the time of service are subject to a $20 administrative fee. We would like to know if any billing creates a true financial hardship as we do not wish to have any patient's care interrupted.

Effective May 1, 2015, E. Joseph Nadji, MD, Inc. acquired the practice of Michael Reynard, MD. Dr. Michael Reynard continues to see patients belonging to the practice on a part-time basis.

Dr. Nadji shares the overhead expenses with another ophthalmologist in his office. You may elect to see another ophthalmologist in the office during an emergency or during a period of cross-coverage. In your interest, you may give permission to allow the other physician to view your medical records. Please understand that ophthalmologists in our office are not a partnership; treatment, billing, and insurance issues, are completely separate. It is also important that you realize that an ophthalmologist in the office may be a participating provider for an insurance carrier that is not affiliated with another treating ophthalmologist.

Please note that dilation of your pupils for an eye examination may blur your vision for at least several hours. It is important to refrain from driving and from performing fine work with tools when your vision is too blurry. You may be given a prescription for a medication refill. It is important that you check with your pharmacist regarding potential interactions with other medications you are taking. We recommend that you check with www.fda.gov/cder/drug/DrugSafety/DrugIndex.htm to become aware of all potentials risks, benefits, and interactions for all medications you take.

PLEASE LET US KNOW IF THERE IS ANY CHANGE IN YOUR ADDRESS OR INSURANCE COVERAGE.
We hope to make your experience pleasant and worthwhile.

I have read the above and agree to its terms and conditions.

PATIENT SIGNATURE: ____ DATE:______________

PATIENTS EXTENDED SIGNATURE AUTHORIZATION
AUTHORIZATION FOR INSURANCE PAYMENT
INSURANCE/MEDICARE ADVANCE NOTICE REQUIREMENT
OFFICE POLICY NOTIFICATION

Statement to permit payment of **Medicare** or **Other Insurance Benefits** to Physicians.

New insurance beneficiary regulations allow physicians to obtain from the beneficiary and retain in their files a lifetime signature authorization of the physician to submit assigned or unassigned claims in the beneficiary's behalf.

The beneficiary must sign a brief statement as follow:

_________________________ _________________________

Name of Patient Social Security #

"I request that payment of **Medicare or other Insurance Benefits** be made to Erfan Nadji M.D. for any services furnished to me by that physician. I authorize any holder of insurance benefits about me to release to Erfan Nadji, M.D. any information needed to determine these benefits or the benefits payable for related services. In addition, I authorize Erfan Nadji, M.D. to act on my behalf in filing consumer requests for assistance to appropriate authorities in the event of delayed or inadequate insurance payment.

I understand that medical insurance may not cover refraction for spectacles or contacts, eyelid surgery that is deemed cosmetic, punctual plugs, administrative reports, medical record copying and transfer, refractive surgery or supplies for surgical procedures. If the insurance carrier determines that a particular service is not 'reasonable and necessary' such as under Sections, 1842 and 1862 of the Social Security Act, the insurance carrier will deny payment of the service. If payment is denied, I agree to be personally and fully responsible for payment when billed. I understand I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney fees. I understand that appointments canceled without 24 hours notice may be subject to an administrative charge.

I acknowledge that the Notice of Privacy Policy for Erfan Nadji, M.D. has been made available to me.

A photocopy of this authorization is as effective and valid as the original.

_______________________________ ________________

Signature of patient Date

Erfan Nadji, M.D.
1301 20th Street Suite 260
Santa Monica, Ca. 90404

PATIENT PRINT NAME: ____

Please answer the following questions about your medical status and history:

Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)

☐ Yes ☐ No If YES, please explain:____

Have you ever had any surgery?

☐ Yes ☐ No If YES, please provide date and reason ______________________________

Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or “lazy” eye, retinal detachment)?

☐ Yes ☐ No If YES, please explain:____

Have you ever had any eye surgery?

☐ Yes ☐ No If YES, please explain: ____

Do you take any medications?

☐Yes ☐ No If YES, please list: ____

Do you take any EYE medication?

☐Yes ☐No If YES, please list: ____

Do you have any drug or food allergies?

☐Yes ☐No If YES, please list: ____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS? **If YES, please explain:**

Chronic fever, unexpected weight loss/gain, fatigue………………………………..Yes/No______________

Ear/Nose/throat problems (e.g. hearing loss, sinus problems, sore throat)……...Yes/No______________

Heart problems (e.g. chest pain, irregular heartbeat)…………………….….....…Yes/No______________

Respiratory problems (e.g. shortness of breath, wheezing, coughing) ………......Yes/No______________

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)...Yes/No______________

Urinary problems (e.g. pain or discomfort, blood in urine) ………………………...Yes/No______________

Skin problems (e.g. rashes excessive dryness) …………………………………..…Yes/No______________

Musculoskeletal problems (e.g. muscle ache joint pain, swollen joints) ……….....Yes/No______________

Neuralgic problems (e.g. numbness, weakness, headaches, paralysis) ……........Yes/No______________

Psychiatric problems (e.g. depression, anxiety) ……………………………..…....Yes/No______________

Family and Social History

Do any medical or eye disease run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration) ☐ Yes ☐ No If YES, please list ______________________________

____

Do you smoke? If yes, how much? _________________. Drink alcohol? If yes, how much __________

If employed, how many hours per week do you work? ______________

M.D. SIGNATURE: ____ *DATE:* ___________________