New Patient Registration Form

Patient Full Name :

Birthday :

Age :

Gender : ☐ Male ☑ Female

Address :

Email Address :

Social Security # :

Marital Status : ☐ Single ☐ Married ☐ Widowed ☑ Divorced ☐ Separated

Work Phone #:

Cell Phone # :

Home Phone # :

Patient Information

Ethnicity :

Race :

Preferred Language :

Retired/ Occupation :

Referred By :

Phone # :

Primary Care Doctor:

Phone # :

Preferred Pharmacy :

City :

Responsible Party Information

His / Her Name :

Relationship to Patient :

Address :

Social Security # :

Birthday :

Insurance Information

Primary Medical Insurance -

Insurance Name :

Policy Number :

Phone # :

Group Number :

Secondary Medical Insurance -

Insurance Name :

Policy Number :

Group Number :

Phone # :

History of Present Illness

Please describe your symptoms :

Are you having any difficulty seeing? ☑ Yes ☐ No

Do you wear glasses? ☑ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☑ No

Have you been told there is prism or slab off in your lenses? ☐ Yes ☐ No ☑ Unsure

Do you have a copy of your eyeglass and/or contact lens prescription? ☐ Yes ☑ No

If Yes, Please bring along a copy along with you to your appointment

Previous Eye Doctor:

Past Eye History

Check any of the following you have had or are known to have.

☐ Bell's Palsy ☐ Botox ☐ Cataract ☐ Color Visual Abnormality ☐ Crossed eyes ☐ Drooped Lid ☑ Dry eyes
☐ Eye injury ☐ Eye or Eyelid Surgery ☐ Floaters ☐ Glaucoma ☐ Iritis ☐ Keratoconus ☐ Lazy Eye (Amblyopia)
☐ Macular or Retinal Disorder ☐ Night Blindness ☐ Ocular Migraine ☐ Pterygium ☐ Refractive/LASIK Surgery
☐ Uveitis ☐ Vision Loss ☐ Visual Field Defect

List any EYE MEDICATIONS you use (drops, ointment, pills) :

Past Medical History

Check any of the following medical conditions that apply to you.

- [ ] Arrythmia - [ ] AIDS - [ ] Cancer or Tumor - [ ] Carotid Surgery - [ ] Depression - [ ] Dizziness - [ ] Emphysema

☐ Arrythmia ☐ AIDS ☐ Cancer or Tumor ☐ Carotid Surgery ☐ Depression ☐ Dizziness ☐ Emphysema
☐ Genetic Disorder ☐ Heart Disease or Surgery ☐ Herpes (cold sores or fever blisters) ☐ Histoplasmosis
☐ Kidney Stones ☐ Leukemia ☐ Lymphoma ☐ Meniere's Disease ☐ Myasthenia Gravis ☐ Parkinson's
☐ Polymyalgia Rheumatic (PMR) ☐ Seizures ☐ Sinus ☐ Skin Cancer ☐ Sleep Apnea ☐ Thyroid Disorder
☐ Tuberculosis ☐ Arteriosclerosis (hardening of the arteries) ☐ Asthma ☐ Arthritis (osteo/rheumatoid)
☐ Chemotherapy ☐ COPD ☑ Diabetes ☐ Epilepsy ☑ Gastric Bypass Surgery ☐ Gout ☐ Hepatitis
☑ High Blood Pressure ☐ HIV Positive ☐ Latex Allergy ☐ Lupus ☐ Migraine Headaches ☐ Multiple Sclerosis (MS)
☐ Pacemaker ☐ Psoriasis ☐ Rosacea ☐ Sickle Cell ☐ Sjogrens Syndrome ☐ Skin Diseases ☐ Stroke
☐ Trigeminal Neuralgia ☐ Other

If "Other" Please Explain

Have You Had : ☐ Hearing Loss ☐ Weight Loss ☐ Fatigue ☐ Fever ☑ None

Do You Smoke? ☐ Yes ☑ No

Do You Drink Alcohol? ☐ Yes ☑ No

List any known ALLERGIES to Medications :

List your current DAILY MEDICATIONS (including birth control pills, nonprescription drugs, recreational drugs, herbal remedies and any vitamins) :

List any surgeries or hospitalizations you have had at any point in your life:

Vaccination Status:

For patients 65 and older: Have you received a pneumonia vaccination? ☑ Yes ☐ No

For patients 65 and older: Have you received a shingles vaccination? ☑ Yes ☐ No

Advance Care:

For patients 65 and older: Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☑ No

For patients 65 and older: Do you have an advanced medical directive or living will? ☐ Yes ☑ No

Family History -

Check any of the following that your blood relatives have had.

☐ Glaucoma ☑ Macular Degeneration ☐ Migraines
☐ Retinal Detachment ☑ Diabetes ☐ Vision Loss

Patient Acknowledgement Regarding Precautions Following Dilation

It is necessary to dilate your eyes during your eye examination or treatment. Dilation results in light sensitivity and an inability to see clearly for a few hours. We provide free disposable sunglasses. Patients would wear sunglasses outdoor and be cautious when walking and going up or down stairs. We recommend that you not drive or operate dangerous machinery immediately after dilation. We also recommend that someone accompany you to your appointment to drive you home, or that you wait until your eyes return to normal so that you can drive safely.

Refraction Service and Fee

The refraction is the part of the eye exam that determines your best corrected vision and if you need corrective eyeglasses. It is an essential part of an eye examination and is necessary to write a prescription for glasses.

Refraction is NOT a covered service by Medicare or most insurance plans. These plans consider refraction a "vision" service rather that a "medical" service.

The refraction fee is collected at the time of service in addition to any copayment your insurance plan may require. Should your insurance plan pay us for the refraction, we will reimburse you accordingly.

I have read and understand the above information. I accept full financial responsibility for the cost of the refraction, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

☑ I Agree

***NOTE:** It is the patient's responsibility to check if we are in a out-of-network with their insurance plan prior to their **first** visit
***NOTE:** It is the patient's responsibility to file insurance claims if we are not contracted with your insurance company.
***NOTE:** Be aware that most medical insurance plans do not cover Routine Exams, Refractions or Contact Lens Analysis.

I understand that all charges for professional services rendered are my responsibility. I understand this office, if contracted with my insurance company, will file a claim to my insurance company on my behalf. Medicare claims will be taken on assignment.

☑ I Agree

I authorize payment of medical benefits to George M. Salib, M.D., Inc. ☑ I Agree

Medicare Accept Assignment Policy

Your doctor will accept the fee approved by Medicare as payment in full for any covered services. The patient will be responsible for any amount approved but not paid by Medicare (the 20% co-payment and the annual deductible) as well as the full amount for all non-covered services.

Most diagnostic eye examinations and tests are covered by Medicare, however, refractions and the fitting and supply of glasses and contact lenses are non-covered services.

I agree to assume responsibility for co-payments and deductibles as specified by Medicare and for the charges of any non-covered services.

☑ I Agree

Notice to Consumers

George M. Salib, M.D. is licensed and regulated by the Medical Board of California.

(800) 633-2322 **www.mbc.ca.gov**

HIPAA Notice of Privacy Practices

George M. Salib, M.D. Inc. HIPAA Notice of Privacy Practices Effective 8/01/2011

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. If you have any questions about this notice, please contact George M. Salib, M.D. at (949) 770-1322. This notice describes the privacy practices at our office.

We are required by law to:

*Maintain the privacy of protected health information. *Give you this notice of our legal duties and privacy practice regarding your health information. *Follow the terms of this notice currently in effect.

How we may use and disclose your health information.

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to George M. Salib, M.D.

Treatment - We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment - We may use and disclose your health information so that others or we may bill and receive payment for you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations - We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminder, Treatment Alternatives and Health-Related Benefits and Services - We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.
Individuals Involved in Your Care or Payment for Your Care - When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.
Research - We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.
As Required by Law - We will disclose your health information when required to do so by international, federal, state or local law.
To Avert a Serious Threat to Health or Safety - We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public.

Disclosures will be made only to someone who can prevent the treatment.
Business Associates - We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.
Military and Veterans - If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.
Worker's Compensation - We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required to do so by law.

Health Oversight Activities - We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement - We may release your health information request by law enforcement official if 1)there is a court order, subpoena, warrant, summons or similar process; 2)if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3)the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4)the information is about a death that may be the result of criminal conduct; 5)the information is relevant to criminal conduct on our premises; and 6)it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors - We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities - We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody - If you are an inmate of a correctional institution or in custody we may disclose your information. 1)for the institution to provide you with health care, 2)to protect your health and safety or that of others and 3)for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy - You have the right to inspect and copy your medical and billing records by written request to George M. Salib, M.D.
Right to Amend - You have the right to request an amendment to your records by written request to

George M. Salib, M.D.
Right to an Accounting of Disclosures - You have a right to an accounting of certain disclosures by written request to George M. Salib, M.D.
Right to Request Restrictions - You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to George M. Salib, M.D. We are not required to agree with your request, but we will try to comply.
Right to Request Confidential Communication - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to George M. Salib, M.D. We will accommodate reasonable requests.

CHANGES TO THE NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice a the any visit or by written request to George M. Salib, M.D.
George M. Salib, M.D., Inc, 24422 Avenida De La Carlota #110, Laguna Hills, CA 92653, USA
Phone: (949) 441-5444.

RELEASE OF MEDICAL INFORMATION

I authorize release of my medical information to the following persons. ☑ I Agree

Name :	**Relationship :**
Phone #:	**Address :**
Name:	**Relationship:**
Phone #:	**Address :**
Name:	**Relationship:**
Phone #:	**Address :**

I hereby acknowledge that I received a copy of this medical practices's Notice of Privacy Practices and that I will be offered a copy of any amended Notice of Privacy Practice at each appointment.

☑ I Agree

Physician-Patient Arbitration Agreement

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 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 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 the Intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated Including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action In any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

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 of a demand for a neutral arbitrator by either party. 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 or witness fees, or other expenses Incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting In the capacity of arbitrator under this contract. This Immunity shall supplement, not supplant, any other applicable statutory or common law.

Article 4: **General Provisions:** 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 California statute of limitations, or (2) the claimant fells to pursue the arbitration claim In accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (induding, but not limited to, emergency treatment) patient should initial below:

Initials

Effective as of the date of first medical services.

☑ I Agree

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.
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.

Patient Consent Form - Orange County Eye Institute

Please read carefully and place your signature in the designated area to confirm that you had read and understood each section of this consent form.

Coverage Terms

Your insurance policy is an agreement between you and your insurance company. It's your responsibility and not that of Dr. Salib's office to know your policy terms and conditions. We try to verify your eligibility and benefits as a courtesy. However, we would know the exact details of payments only after claims are processed.

Authorization

If your insurance company requires authorization from your Primary Care Provider, it is your responsibility to obtain the relevant authorization before your visit. Otherwise, bearing the cost of your visit would be your responsibility.

Insurance Company Disputes

The negotiation of payments that are due to your service providers or the settling of any disputes that may arise between you and your insurance company is entirely your responsibility.

Payment/Outstanding Balances

All payments and copays are due at the time of receiving the service. Any outstanding balances should be settled before the visit of the physician. We stress on all account balances being current. We can work with you on convenient payment plans, should you require so.

Collection Policy

You will be responsible for interest and penalties if payments are not settled upon receiving the monthly billing statement. Any unpaid debt to Dr. Salib's office is handled by a third party collection company. If your account is sent to collections, you are responsible for settling any attorney fees, interest, or penalties applicable by law. You may even be discharged from the practice if your account is sent to collections.

Copy of Medical Records or Disability Paperwork

If you need any medical records from us, please send a written request to authorize the release of such records. We charge $25 upfront for copies of medical records or disability paperwork. Please note that processing takes 1 - 2 weeks from the date of receipt of such requests.

Missed/Cancelled Appointments

Please note that we will charge $50 for any canceled/missed appointments unless we are notified of such, 48 business hours in advance. The charge will be $100 if your appointment was for a scheduled in-office procedure. The cancellation fee is entirely your responsibility and won't be covered by your insurance provider.

Late to Appointments

If you are more than 15 minutes late for your appointment, please understand that you may have to reschedule your appointment.

Cash Agreement

I acknowledge that I am responsible for the cost of my visit at the Orange County Eye Institute and or any testing done if my insurance information is not provided at the time of visit or insurance information is inaccurate, inactive or ineligible.

- [x] I Agree

If you have any concerns please do not hesitate contact the office at (949) 770-1322

Consent to Audio and Video Recording

I understand that Orange County Eye Institute has audio and video surveillance in its office spaces for quality assurance purposes, whereby it records all conversations in its offices (other than in the restrooms and patient consulting rooms). I consent to video recording and to the audio recordings of my conversations while I am at Orange County Eye Institute's premises, and acknowledge that I have no expectation of privacy in my communications while I am on its premises.

☑ I Agree

Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name

Notifier: Orange County Eye Institute, 24422 Avenida De La Carlota Suite 110, Laguna Hills CA 92653. Phone 949-770-1322.

NOTE: If Medicare doesn't pay for **D. REFRACTION** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We accept Medicare may not pay for the **D. REFRACTION** below,

D.	E. Reason Medicare May Not Pay:	F, Estimated Cost
REFRACTION OF THE EYE	NOT A COVERED BENEFIT	$75.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. REFRACTION listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. REFRACTION listed, above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but 1 can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you less co-pays or deductibles.

☑ OPTION 2. I want the D. REFRACTION listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment 1 cannot appeal if Medicare is not billed.

☐ OPTION 3. 1 don't want the D. REFRACTION listed above. 1 understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H, Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According lo the PaperWork Reduction Act of 1955, no persons arc required to respond to a collection of information unless it displays a valid OMD control number, The valid OMB control number for this information collection is 0938-0566, The lime required to complete this Information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection, if you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write lo: CMS, 7500 Security Boulevard, Aim: PIUV Reports Clearance Officer, Baltimore, Maryland 21244-IS50,

Your Signature :

Date:

Date:

Patient Name :

(Your digital signature (full name) is as legally binding as a physical signature.)

Email sent to patientsubmissions@webpatientforms.com

[Download The Notice of Privacy Practices From Here]