Dr. Anand Bhatt

801 N Tustin Ave. #700, Santa Ana, CA 92705
Phone: 714 541 4185
Fax: 714 541 3465

www.occataractandglaucoma.com

Date_____

PATIENT INFORMATION

Dr./Mrs./Ms./Mr. First Name_____M.I._____ Last Name_____

Sex: M F SSN_____ Date of Birth_____ Age_____

Marital Status Married Single Partnered Divorced Widowed

Mailing Address _____

City_____ State _____ Zip_____ Email_____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship_____

Pharmacy Name _____ City/Street name_____

Referring Doctor _____

Primary Care Doctor _____

Optometrist _____

How did you hear about us?

Referral from Physician Our Website Google Advertisement Friend_____

HEALTH HISTORY

EYE HEALTH (CIRCLE)

BLEPHARITIS
CATARACT
CATARACT SURGERY
DRY EYE
GLAUCOMA
GLAUCOMA SURGERY
LAZY EYE/AMBLYOPIA
DOUBLE VISION
MACULAR DEGENERATION
EYE INFECTIONS
EYE ALLERGY
STRABISMUS
PTOSIS/DROOPY EYELIDS
RETINAL DETACHMENT
LASIK
VISION LOSS
DIABETIC EYE DISEASE

PAST MEDICAL HISTORY (CIRCLE)

AIDS/HIV
ARTHRITIS
ARTIFICIAL VALVE
ARTIFICIAL JOINTS
ASTHMA
AUTOIMMUNE DISEASE
BLEEDING ISSUES
CANCER
STROKE
COPD
DIABETES
EMPHYSEMA
EPILEPSY
HEART CONDITION
HEPATITIS
HIGH BLOOD PRESSURE
KIDNEY DISEASE
LUPUS
MIGRAINES
PACEMAKER
RHEUMATOID ARTHRITIS
RHEUMATIC FEVER
SHINGLES
SKIN CONDITIONS
THYROID DISEASE
TUBERCULOSIS
SARCOIDOSIS
SYPHILIS

Have you had any prior eye surgeries or other medical history not listed?

_____

_____

_____

_____

Do you smoke? Y N

Do you drink alchohol? Y N

Do you use illegal drugs? Y N

Eye Medications

_____

_____

_____

_____

Oral Medications_____

_____

_____

Allergies _____

DO YOU WEAR CONTACT LENSES? Y N

HAVE YOU HAD LASIK/PRK/RK SURGERY? Y N

Insurance Information

If you would like us to file claims with insurance for services rendered, please provide your most current insurance card(s) and ID to be scanned into your chart. You are also responsible for notifying our office promptly with any change to your insurance coverage to ensure that your coverage is active. **You may be required to obtain an up-to-date referral from your primary care physician before insurance will pay for an exam.** While it is the responsibility of the patient to obtain referral authorization before their visit, our office will do everything possible to obtain the referral for you if you have not done so already. Per the contract between you and your insurance company you will be responsible for any charges if a referral cannot be obtained and your insurance company denies payment.

FINANCIAL POLICY

Orange County Cataract and Glaucoma (OCCG) is committed to helping you receive care and coordinate payment in the most straightforward manner. We ask that you adhere to the following:

1. Insurance: OCCG will attempt to verify your benefits and coverage prior to your visit. However, there is no guarantee that your insurance company will pay for services rendered by our practice. Insurance coverage is a contract between patients and their insurance company. It is your responsibility to provide us with your current address, telephone number, email address, and insurance information at each visit. **We require that co-pays, applicable deductibles, and co-insurance be paid at the time of service.** If a balance is incurred, we will send you a statement for outstanding balances
2. Referral and Preauthorization: You are required to know whether or not your insurance requires a referral for medical or surgical treatment and obtain that referral prior to seeing our doctors. Our office will assist you in determining if OCCG is in network or out of network with your insurance, however this is not a guarantee of coverage. Referrals usually have an expiration date and a limited number of visits and it is your responsibility to monitor your referral status
3. No Insurance: Patients without insurance coverage are expected to pay in full at the time of service unless prior arrangements have been made. You may receive a prompt pay discount on services when paid in full at the time of service.
4. Returned Checks: Your account will be charged $25 for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the returned check and a $25 fee
5. Past due accounts: Patients who have not made an effort to make payment arrangements or have not met their financial obligation will be turned over to a collection agency for all correspondence regarding the balance. OCCG is authorized to automatically collect payment via credit card for any past due balance when credit card information is on file
6. Non-Covered Services: OCCG will make a concerted effort to inform you if we believe a service may not be covered by your insurance. In our professional judgement, these services may be needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services even if your insurance denies payment
7. Appointment Cancellations and No Shows: As a courtesy to patients waiting for appointments, if you need to cancel or reschedule your appointment, please give our office at least 24 hours' notice. **Failure to give proper notice of cancellation or failure to keep your appointment will result in a charge of $50**. If this happens our office reserves the right to keep a credit card on file if you wish to reschedule.
8. Credit Card on File: If you have a high deductible plan with an unmet deductible, **we may require a credit card be kept on file. By providing your credit card on file, you authorize the practice to collect any deductible due by charging your credit card upon insurance processing.**

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS

I understand I am financially responsible for any and all charges incurred during the course of authorized treatment. I further understand that all applicable fees are due on the date that services are provided and agree to pay such charges in full. I hereby assign all medical and surgical benefits from my medical insurance to OCCG. I authorize and direct my insurance carrier to issue payment to OCCG for medical or surgical services rendered to myself or my minor children. I understand I am responsible for any amount not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I authorize OCCG to release any information necessary to insurance carriers regarding my treatment, process insurance claims generated in the course of examination, and allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. I authorize OCCG to disclose PHI, including lab results and diagnoses, in messages left on my voicemail at the following number_____ and to the following persons_____

REFRACTION POLICY

The doctor may perform a refraction to determine your glasses prescription. The refraction is also necessary to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you which lens makes an image better or worse. A refraction may be needed as part of a comprehensive eye exam but is not covered by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if a refraction occurs a charge of $65 may be collected in addition to your copayment

DILATING DROPS AND CONSENT TO TREAT

Dilating eye drops are used to enlarge the pupil of the eye to allow for a complete examination of a cataract and posterior segment of the eye. These drops will blur your vision for a varying length of time and can make you sensitive to bright light. It is not possible to predict how much any individual's vision will be affected. I have requested medical services to be provided to myself or my minor child and agree and understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that OCCG recommends that I find an alternate mode of transportation. I hereby authorize OCCG to administer dilating eye drops as they may be necessary to diagnose or treatment my eye condition

I have understood and agreed to the above the policies

Patient/Guardian_____ Date_____

Orange County Cataract and Glaucoma
HIPAA Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

"Protected health information," is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable cost-based fee.

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no," to your request, but we will tell you why in writing within 60 days.

You can ask us to contact you in a specific way, (for example, home, cell, or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no," if it would affect your care. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures (such as any you asked us to make). You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health
information. We will make sure the person has this authority and can act for you before we take any action.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.
Angelina McClain, HIPAA Compliance Officer (562)531-2020

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it

is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health safety.

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

We can share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

We can use or share your information for health research.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can share health information about you with organ procurement organizations

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law.

<u>Our Responsibilities</u>

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
  We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. •We will never share any substance abuse treatment records without your written permission.
- Changes to the Terms of this Notice
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I acknowledge that I have read and understood the above notice

Patient/Guardian_____ Date_____