Astorino & Associates Eye Center

Thank you for giving us the opportunity to care for your eyes. We will do our best to make your visit here a pleasant experience. All information will be kept confidential.

Date_____

Patient Name (Last)_____ (First)_____ (MI)_____

D.O.B._____ SSN#_____ Age ____ Marital Status_____ Sex M F

Address_____ City_____ State____ Zip_____

Home Phone_____ Cell_____ E-Mail_____

Employer/Occupation_____ Phone_____

Emergency contact (not living with you):

Name_____ Relationship_____ Phone_____

Are you seeing a local optometrist for your eyeglasses or contact lenses? Yes No

Name_____ Phone_____ Address_____

How did you hear about our office? Insurance Internet website _____ Other_____

Doctor referral (Name)_____ Phone_____

Friend referral (Name)_____ Is your friend a patient here? Yes No

Vision Insurance_____ Policy #_____

Medical Insurance_____ Policy #_____ Co-pay $_____

Secondary Insurance_____ Policy #_____ Co-pay $_____

Responsible Party _____ SSN#_____ D.O.B._____

Address_____ Relationship to Insured_____

Medicare and Private Insurance Assignment of Benefits:
I request that payment of authorized Medicare and Private insurance benefits be made to Astorino & Associates Eye Center, for services furnished to me by the physician, practice or supplier. I permit a copy of this authorization to be used in place of the original and authorize any information needed to determine the benefits payable for related services. I understand that I am responsible for my deductible, co-insurance, co-pay, and non-covered services. **Glasses, contact lenses, refractions, PAM tests and DMV tests are not covered by Medicare or any other medical insurance.**

Patient/guardian signature_____ Date_____

Astorino & Associates Eye Center

Health History

Please List
Medical Doctors: Specialty Phone

_____

_____

_____

Eye injuries, eye surgeries, or serious eye infections (type and date)

_____

_____

What tablets, pills, or liquids do you take? Include all medication, including aspirin, vitamins, birth control, and eye drops.

Name How Much How Often For What How Long

_____

_____

_____

_____

_____

Past Surgeries:

_____

_____

Please circle any of the following symptoms or conditions that apply to you:

Eyes: Tearing Sudden loss of vision Sensitivity to light Eye redness Itching Burning Distorted vision Flashes of light Floaters Shadows

Lungs: Asthma Bronchitis Tuberculosis Smoker

Heart: Heart attack High blood pressure Stroke Chest pain Shortness of breath Swollen ankles

Other Medical Problems: Diabetes (how long_____) Thyroid disease (how long___) Kidney problems Arthritis Skin problems Cancer or other tumors Abnormal bleeding Prolonged healing Fainting Seizures

Allergies: Penicillin Novocain Aspirin Sulfa Neomycin Other:_____

If you have a condition or illness not listed above that you think the doctor should know about please list:

_____

_____

_____

The above information is correct to the best of my knowledge. I understand that payment is expected when services are rendered.

Patient/guardian Signature_____ Date_____

Astorino & Associates Eye Center

Office Policies

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advanced by our office staff. Our office accepts payments in the form of cash, personal checks, and all major credit cards. A $25 fee will be charged for all returned checks.

Our office is NOT an HMO provider. If you do NOT have a PPO option on your plan, then you will be responsible for all charges at the time services are rendered. Patients with a POS plan, please be aware that benefits will be processed as out of network. Co-pays are always due at the time services are rendered.

Our office will bill your medical and/or vision insurance as a courtesy to you. However, it is the policy of this office not to enter into any dispute with an insurance carrier. A dispute over payment of claims is the responsibility of the patient. In the event that your insurance carrier will not make payment for services rendered, it is your responsibility to see that payment is made. It is also your responsibility to inform our office of any new insurance or changes to existing insurance. Incorrect insurance information could lead to a delay in claims processing and may result in the balance being transferred to the patient. We are happy to make any and all efforts on your behalf to insure that your insurance carrier makes proper payment for services rendered. We also ask that you remain an active part in this process.

Your insurance company may request additional information from you and will not pay your claim until they receive the information requested. The balance is your responsibility until the claim is processed. It is the responsibility of the patient to know the details of your individual health plan. If you are in doubt as to whether a procedure or test is covered, please contact your plan's member services department. This office will not be responsible for out of pocket expenses from utilizing an out of network provider or undergoing non-covered tests or procedures.

Occasionally, an insurance carrier will send payment to the patient. If this occurs please bring us the check and the attached stub. The information on the stub is very important.

Patients with a Vision Insurance are required to inform our office PRIOR to the examination to ensure that proper authorization has been obtained. The member's co-pay will be collected at the time services are rendered. We participate with Medical Eye Services and Vision Service Plan. Please note that there are many different types of VSP plans and our office is not contracted with all of them. We will advise you prior to your exam if you subscribe to one that we do not participate with.

Monthly statements will be mailed to all patients with an outstanding balance. Please note that any charges that have been paid in full will not show up on your statement.

For glasses and contact lenses, payment is required in full at the time the order is placed.

If you are unable to keep an appointment please give our office notice at least 24 hours in advance by calling (949) 645-2250.

I have read the above statement of policy, and understand that I am financially responsible for any and all treatment I receive at Astorino & Associates Eye Center.

Patient Name_____ Signature_____ Date_____

Astorino & Associates Eye Center

Refraction & Contact Lens Fees

An important component of an eye exam is refraction. Refraction is a test that is performed to determine whether your vision can be improved with new glasses or contact lenses. It is also used to determine the best possible visual acuity and function of your eye, which is essential medical information that allows the doctor to assess the health of your eyes. A refraction is necessary to determine how a condition such as cataracts, macular degeneration, or glaucoma is affecting your vision.

The refraction fee is **$75.** If you have vision insurance such as VSP or MES, this fee is covered as part of your plan. **Medicare and other medical insurance plans DO NOT cover refraction and you will be responsible for this payment on day of service.** These plans consider refraction a "vision" service and not a "medical" service.

The refraction fee is collected at the time of service in addition to any co-payment your plan may require. Refractions may be repeated at no charge for up to 3 months if needed.

Should you be interested in contact lenses, please review our contact lens fitting and evaluation fees below:

	Existing Patients		New Patients	
Lens Type	No change in lens type	Change in lens type	Previous CL wearer	No prior CL wear
Spherical	$70	$90	$100	$120
Toric	$80	$110	$120	$140
Monovision Multifocal	$90	$130	$140	$160
Gas Permeable	$100	$140	$160	$180

A contact lens evaluation and fitting is required for all contact lens prescriptions to determine the optimal lens type and power for your eye. Contact lens prescriptions have a specific brand, power, and fit measurement and are different from glasses prescription. The contact lens evaluation and fitting fee is a global fee that includes trial lenses (if necessary) and all follow-up visits for up to 3 months. If the contact lens prescription is not finalized within 3 months, the fee will be charged again. Fees for specialty contact lenses, such as prosthetics, will vary. **Medicare and other medical insurance plans DO NOT cover contact lens services and materials.** These fees may be covered in part if you have vision insurance such as VSP or MES.

I understand that I am responsible for payment on all non-covered services such as refraction and contact lens fittings at the time services are rendered.

Patient/guardian signature_____ Date_____

Astorino & Associates Eye Center

Mutual Agreement

Welcome to Astorino & Associates Eye Center! We know there are a wide variety of ophthalmology offices to choose from and we thank you for choosing us.

We take great pride in our reputation for providing the highest level of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcome of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if they feel we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country, claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board certified experts will help expedite resolutions and concerns.

Our commitment to you:
We commit to using only American Board of Medical Specialties (AMBS) board certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics. We demonstrate this commitment to you with a signature on this form.

What we are asking you to do:
We are asking you or any representative to commit to this process also, by using only board certified physicians expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.

"I", "Patient/Guardian" shall be understood to mean (Name)_____.
"Dr. Astorino" shall be understood to mean Dr. Arthur Astorino Jr. M.D. and Patients First Medical Corporation.

I understand that I am entering into a contractual relationship with Dr. Astorino for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. Astorino, I, and or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Dr. Astorino.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and or my representative agree to use American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in the same specialty as Dr. Astorino. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and or code of conduct defined for expect witnesses by the A.B.M.S. In further consideration for this, Dr. Astorino agrees to the same stipulation.

Physician Signature_____ Date_____

Patient/guardian signature_____ Date_____

Astorino & Associates Eye Center

Mutual Agreement (Part Two)

Dr. Arthur Astorino Jr. and Patients First Medical Corporation (collectively labeled "Dr. Astorino") agree to provide treatment to_____("Patient"). Dr. Astorino takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and state privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Astorino believes this is improper and may not be in the patient's best interest. Accordingly, Dr. Astorino agrees not to provide medical information for the purpose of marketing directly to the patient. Regardless of legal privacy loopholes, Dr. Astorino will never attempt to leverage his relationship with the patient by seeking the patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Dr. Astorino has invested significant financial and marketing resources in developing the practice. Nothing in this agreement prevents a patient from posting commentary about Dr. Astorino, his practice, expertise, and/or treatment on web pages, blogs and/or mass correspondence. In consideration for treatment and the above noted patient protection, if the patient prepares such commentary for publication on web pages, blogs and/or mass correspondences about Dr. Astorino, the patient exclusively assigns all intellectual property rights, including copy rights, to Dr. Astorino for any written, pictorial, and or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This agreement shall be enforceable for a period of five years from Dr. Astorino's last date of service to the patient. As a matter of office policy, Dr. Astorino requests all patients in his practice to sign the mutual agreement so as to establish that any anonymous or pseudonyms publishing or airing of commentary will be covered by this agreement for all of Dr. Astorino's patients. Further, this agreement will survive for a minimum of three years beyond any termination of the physician-patient relationship.

The patient and Dr. Astorino acknowledge that breach of the agreement may result in serious, irreparable harm. The patient and Dr. Astorino agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

The patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient/guardian signature_____ Date_____

Astorino & Associates Eye Center, A Medical Corporation

1525 Superior Ave. Suite 101, Newport Beach CA 92663

949-645-2250 fax: 949-645-9864

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Astorino & Associates Eye Center ("AAEC") including AAEC entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of AAEC's Notice of Privacy Practices that describes how my health information is used and shared. I understand that AAEC has the right to change this notice at any time.

I acknowledge receipt of the Notice of Privacy Practices of Astorino & Associates Eye Center.

Patient's Name: _____

Signature: _____ Date: _____
[Patient/Parent/Conservator/Guardian]

If signed by other than patient, indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- ☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.
- ☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.
- ☐ Other: _____

Patient's Name: _____

AAEC Staff Signature: _____ Date: _____