LONG BEACH RETINA

Last name:

First name:

Preferred name:

Middle name: Suffix:

Former last name:

Sex: ☐ Male ☐ Female

DOB:

Social Security #:

Address:

Address (continued):

Zip Code:

City:

State:

Home phone: ( ) - ☐ None

Mobile phone: ( ) - ☐ None

Work phone: ( ) - ☐ None

Email: ☐ None

Contact Preference: ☐ Home ☐ Work ☐ Mobile ☐ Mail

Language: ☐ Decline

Race: ☐ Decline

Ethnicity: ☐ Decline

Referring Doctor:

Primary Care Provider:

Primary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

Subscriber DOB:

Subscriber SSN:

Secondary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

Subscriber DOB:

Subscriber SSN:

Emergency Contact:

Relationship:

Phone:

LONG BEACH RETINA

MEDICAL HISTORY
& REVIEW OF SYSTEMS

NAME: _____ DATE:_____

Please check all boxes that apply to you.

Endocrine Problems: ☐ None
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other_____

Cardiovascular Problems: ☐ None
- ☐ High Blood Pressure
- ☐ Heart Attack or Chest Pain (Angina)
- ☐ Abnormal Heart Beat
- ☐ Heart Failure
- ☐ Angioplasty or Heart Surgery
- ☐ Other_____

Respiratory Problems: ☐ None
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- ☐ Other_____

Head/Ear/Nose/Throat Problems: ☐ None
- ☐ Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- ☐ Hearing Loss
- ☐ Other_____

Digestive Problems: ☐ None
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Other_____

Genitourinary Problems: ☐ None
- ☐ Dialysis or Kidney Failure
- ☐ Sexually Transmitted Disease
- ☐ Other_____

Musculoskeletal Problems: ☐ None
- ☐ Osteo Arthritis or Rheumatoid Arthritis
- ☐ Migratory or Moving Joint Pains
- ☐ Lower Back Pains
- ☐ Other_____

Neurologic/Psychiatric Problems: ☐ None
- ☐ Stroke or Transient Ischemic Attacks
- ☐ Mood Disorder: Depression/Anxiety/etc.
- ☐ Other_____

Skin Problems: ☐ None
- ☐ Rashes
- ☐ Sores in Mouth or Genitals
- ☐ Other_____

Cancer: ☐ None
- ☐ Type/s: _____
- _____
- _____

Blood/Immune Problems: ☐ None
- ☐ Bleeding or Clotting Problems
- ☐ Auto-immune Disease _____
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Other_____

Constitutional Symptoms: ☐ None
- ☐ Fever
- ☐ Fatigue
- ☐ Unexpected Weight Loss or Gain

***"Family"* Eye History (Other than You):** ☐ None
- ☐ Macular Degeneration
- ☐ Retinal Tears or Detachments
- ☐ Glaucoma
- ☐ Other_____

Social History: ☐ None
- ☐ Live Alone
- ☐ Live with (relationship) _____
- ☐ Retired
- ☐ Occupation _____

Habits: ☐ None
- ☐ Tobacco use _____
- ☐ Alcohol use_____
- ☐ Street Drug use_____
- ☐ Herbal/Vitamin Supplements _____
- _____
- _____

Surgeries: ☐ None
- _____
- _____
- _____
- _____

Please bring all of your medications, supplements and eye drops or a complete list of them with you to your appointment.

_____ M.D.

LONG BEACH RETINA

MEDICATION & ALLERGY LIST

Patient Name:_____ **DOB:**_____

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES

PREFERRED PHARMACY:

Name_____

Location _____

Phone _____

LONG BEACH RETINA

Financial Policy

GENERAL: Patient authorizes for payment of insurance benefits to be made directly to Long Beach Retina and any assisting physicians for services rendered. Patient is financially responsible for all charges whether or not they are covered by insurance. In the event of default, patient will pay all costs of collection. Patient will authorize for Long Beach Retina to release all information necessary to secure the payment of benefits.

INSURANCE BENEFITS: If the patient is insured, a claim will be sent to the insurance company. It usually takes up to ninety days for the insurance company to pay for a patient's claim. After the insurance company pays Long Beach Retina, we will provide the patient with information about any amount owed. Patients are advised to keep in mind that their policy is an agreement between them and the insurance company. If the patient did not follow the insurance plan's terms, they may not pay for all or part of the patient's care. Long Beach Retina will bill medical insurances. The patient's insurance card and photo ID must be presented at each visit. If the patient does not provide current insurance information at every visit, the organization may miss the window of opportunity to bill you. If this happens, the patient will have to pay Long Beach Retina directly and the patient will have to collect from the insurance.

Long Beach Retina will bill secondary insurance if the organization is a participating provider for that health plan. If patients have any questions regarding Medicare secondaries they are advised to contact the secondary insurance or Medicare.

If the patient is not eligible for insurance benefits on the day services are rendered, the patient will be financially responsible for all the services performed by Long Beach Retina. If Long Beach Retina is not contracted with your insurance plan, please obtain a pre-authorization from your primary care doctor, otherwise on the day services are rendered the patient will be financially responsible for all the services performed by Long Beach Retina. If the patients' insurance requires a primary care physician (PCP) referral and services are rendered at Long Beach Retina, and our organization has not received the referral letter, patient will be held financially responsible for the services performed at/by Long Beach Retina.

BILLING: Co-Pays/Deductibles/Share-of-Cost: Al co-payments/deductibles/share-of-cost are required at the time of visit; otherwise patient will receive a bill for it. We accept credit cards, cash, checks and ATM transactions. Depending on services rendered a co-pay could be added to the service. This charge is required by Medicare and other insurance health plans, therefore Long Beach Retina is required to comply.

PAYMENTS: If patient is ineligible for Medi-Cal and cannot pay for the entire bill, Long Bach Retina will work with the patient to set up monthly payment arrangements. If, after services are received, any additional payment is due, Long Beach Retina will send the patient information about any amount that is still owed. There is a 50 (fifty) dollar service charge on all returned checks. After receiving a returned check, LB retina will only accept cash, credit card or money order. If you have over $250 of remaining balance, we will collect the whole amount before your next visit, which is a policy necessary for efficient practice operations. Collection agencies are utilized for outstanding balances for more than 90 days.

REFERRALS: The patient is responsible for decisions to pursue any referrals from Long Beach Retina to providers and services outside of your insurance or noncontracted, and the patient will be responsible for the bill. Long Beach Retina is not responsible for non-covered services or for the cost of services provided by a non-contracted provider.

SELF-PAY PATIENTS: Long Beach Retina offers a 20% discount from charges to self-pay patients that is consistent with discounts from charges provided to other payors. Self-pay quotes require payment in full on the date of service unless prior arrangements have been made.

LABS & X-RAY SERVICES: When labs and or X-rays are requested there will be a separate bill, from the provider of these services to the patient's insurance. These services are requested through the physician but the cost is generated by the outside organization.

NO SHOW/CANCELLATION APPOINTMENTS: No-shows to scheduled appointments will not lead to a monetary charge, but cancellations without 24 hour notice up to three times may lead to a monetary fine of fifty dollars and possible discharge from the organization. Consideration of patient access to services is important to the practice and the community.

Your cooperation is appreciated. A good doctor/patient relationship is based upon understanding and good communication, if you have any questions regarding financial arrangements please contact Long Beach Retina at (562) 444-8504.

LONG BEACH RETINA

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES
PRIVACY OFFICE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of patient) (Name of person or facility which has information)

release the following health information: _____

Long Beach Retina

To:

3828 Schaufele Ave, suite 360
Long Beach CA 90808

(Name and title or facility name to receive health information)

(Street address, city, state, ZI

To aid in medical care

number)

For the following purposes:

information has been forwarded

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative: _____ On Behalf of _____ Name of Patient	Date

LONG BEACH RETINA

Acknowledgement Form

Notice of privacy practices: I hereby acknowledge that I have been provided the "Notice of Privacy Practices", and I have been provided with an opportunity to review it. **Initials** _____

Financial Policy: I hereby acknowledge that I have read and understand Long Beach Retina financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. **Initials** _____

Consent for treatment: I hereby authorize Long Beach Retina to through physician and/or his assistants, to obtain historical and eligibility data from public and private sources including but not limited to insurance claims data, pharmacy data and prior treating physicians; the information may be necessary to properly diagnose my condition and determine my eligibility for treatment. I authorize Long Beach Retina to obtain medical history, perform appropriate assessment and treatment procedures that may need a specific consent. **Initials** _____

Dilation Eye Drops: Dilating eye drops are used to dilate or enlarge pupils of the eye to allow the ophthalmologist a better view of the internal eye structures. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much of your vision will be affected. Because driving may be difficult immediately after an examination, it is best to make arrangements not to drive yourself, nor operate machinery. Adverse reaction, such as acute angle-closure glaucoma may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Roberto Roizenblatt MD and/or his designated assistants to administer dilating eye drops. The eye drops are necessary to diagnose my condition. **Initials** _____

Consent for photographs: I hereby consent for eye diagnostic photographs to be taken for medical treatment purposes. **Initials** _____

Open payments database: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov **Initials** _____

Confidential Communications Request: I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand I can revoke these at any time by informing the privacy officer of the practice in writing to the mail address below.
Telephone: we may leave a message with a callback number or appointment reminder on voicemail. Cell phone texting: we may leave a message, a callback number, appointment reminder. Written communication: we may mail postcards or letters to your home address or e-mail. **Initials** _____
I further permit copies of this authorization to be used in place of the original.

By listing the names and signing below, I give permission to Long Beach Retina, physician and designated assistants, to speak with the following family members/friends regarding my healthcare.

Name _____ Relationship _____

Covid policy: per current county mandate.

Patient/guarantor/representative signature _____Date_____

Printed name of patient _____

LONG BEACH RETINA

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

LONG BEACH RETINA

Your Rights *continued*

Ask us to limit what we use or share	• 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.
Get a list of those with whom we've shared 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 except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• 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.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • 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/.** • We will not retaliate against you for filing a complaint.

LONG BEACH RETINA

Your Choices

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 payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *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 or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

LONG BEACH RETINA

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• 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.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• 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.

Address workers' compensation, law enforcement, and other government requests	• 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
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Conduct outreach, enrollment, care coordination and case management	• We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.
Appeal a DHCS decision	• We can share your information if you or your provider appeal a DHCS decision about your health care.
Apply for full scope Medi-Cal	• If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Join a managed care plan	• If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.

LONG BEACH RETINA

Administer our programs	• We can share your information with our contractors and agents who help us administer our programs.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

We will never market or sell your personal information.

Our Responsibilities

- 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 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.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

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, on our web site, and we will mail a copy to you.

Effective Date: September 23, 2013

Privacy Officer: Roberto Roizenblatt MD
3828 Schaufele Ave Ste 360 Long Beach CA 90808
Tel 562.444.8504
Fax 562.363.0685