BEACH EYECARE OPTOMETRY
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION						
Today's date:				Updated:		
Last name: First: Middle:				□ Mr. □ Mrs.	□ Miss □ Ms.	Marital status (circle one) Single / Mar / Div/ Sep /Wid
Is this your legal name? □Yes □ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: M F	
Street address:			City:	State:	Zip Code:	
Social Security no.:	Home phone no.: ( )		Cell phone no.: ( )			
Race:	Ethnicity:	Email:				
Occupation:	Employer	Employer phone no.: ( )				

INSURANCE INFORMATION					
Person responsible for bill:	Birth date: / /	Is this person a patient here? □Yes □ No	Home phone no.: ( )		
Address (if different):					
Occupation:	Employer:	Employer address:	Employer phone no.:		
Is this patient covered by insurance? □ Yes □ No					
Please indicate primary medical insurance □ Medicaid □ Medicare □ Blue Shield □ Anthem Blue Cross □ Aetna □ Cigna □ UnitedHealthcare					
Subscriber's name:	Subscriber's SSN"	Birth date:	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other					
Subscriber's name:	Subscriber's SSN:	Group no.:	Policy no.:		
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other					

IN CASE OF EMERGENCY			
Last Name, First Name	Relationship to patient	Home phone no.: ( )	Work phone no.: ( )

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

I have received Beach Eyecare Optometry Privacy Notice.

Signature of patient:_____Date:_____

Parent/guardian signature (if minor):_____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Please check one of the following:

- o Insurance: I hereby authorize and direct payment of my medical and/or vision benefits to Beach Eyecare Optometry for any services furnished to me by the doctors. I authorize the doctors to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical and/or vision services to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.Copays are due at the time of service.
- o Private Pay: I authorize the doctors to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical and/or vision services to other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including any fees for collection services needed.

Signature of patient:_____Date:_____

Parent/guardian signature (if minor):_____

PUPILLARY DILATION CONSENT

Our office routinely dilates every patient to achieve the most comprehensive evaluation of the health of your eyes. Whether pupil dilation is necessary for every eye exam depends on the reason for your eye exam, your overall health and your risk of eye diseases.

Dilating the pupils may cause temporary blurring of your vision. We advise that you exercise caution in operating any equipment or machinery, including driving, until the effects have worn off.

Please check one of the following:

- □ I would like my eyes dilated today if the doctor believes it is necessary
- □ I do not want my eyes dilated (see below)

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Signature of patient:_____Date:_____

Parent/guardian signature (if minor):_____

Medical History Questionnaire

Name:_____Today's Date_____

Medical History

What is your general health?_____ Weight _____ Height _____

Do you currently, or have you ever had any problems in the following systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bone	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Headaches	Yes/No	Integumentary (Skin)	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

If yes, explain: _____

Are you pregnant? Yes/No Are you breastfeeding? Yes/No

Diabetes Yes/No Type _____Date of diagnosis:_____

Other health problems _____

Do you have any allergies to medication? Yes/No If yes, explain:_____

Current prescription or over the counter medication(s):_____

_____

List all major injuries, surgeries and/or hospitalizations:_____

Name of family doctor _____

Do you or have you ever smoked? Yes/No If so, how often?_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye operations? Yes/No Type_____Date_____

Have you had any eye injury? Yes/No Kind _____Date_____

Do you currently, or have you ever had any of the following:

Glaucoma	Yes/No	Cataracts	Yes/No	Dry Eyes	Yes/No
Macular Degeneration	Yes/No	Retinal Detachment	Yes/No	Crossed Eye	Yes/No

Do you wear glasses? Yes/No If how old is your present pair of lenses? _____

Do you wear contact lenses? Yes/No Type_____

Family History

High Blood Pressure Yes/No Relation _____		Macular Degeneration Yes/No Relation_____	
Diabetes	Yes/No Relation _____	Retinal Detachment	Yes/No Relation_____
Glaucoma	Yes/No Relation_____	Cataracts	Yes/No Relation _____

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Long Beach, CA 90815

(562) 596-3838

eyecontact@beacheyecareoptometry.com

We are proud to introduce the latest in retinal imaging, the Optomap. It is painless, quick and the doctor's preferred method at looking at the health of your eye. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as hypertension, diabetes, high cholesterol, and thyroid problems. Through this digital imaging of the retina we can observe early changes in the eye relating to glaucoma, cataracts, and macular degeneration. This technology is now our new standard of care.

There is a nominal fee of $39 to perform this procedure.

Please check one of the following:

☐ Yes, I would like this new procedure. ☐ I want to discuss with the doctor.

Print Name: _____ Date: _____

Signature: _____

This technology can be used without dilation, and will be a permanent part of your medical records. We are happy to email you the images taken today, please let us know where to email them on the line below:

_____

Beach Eyecare Optometry
5531 E. Stearns Street Suite A, Long Beach, CA 90815
Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to a make a routine appointment. We may also call or write to notify you of other treatments of services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home. In addition, when appropriate we may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.