199 West Hillcrest Drive
Thousand Oaks, CA 91360
Office: 805.497.7976 Fax: 805.497.7489

Access Eye Institute

FULL NAME	*DATE OF BIRTH*
ADDRESS	*SSN*
CITY, STATE, ZIP CODE	*DRIVERS LICENSE*
HOME PHONE	*CELL PHONE*
EMAIL	*CIRCLE* *MALE* *FEMALE*

LANGUAGE	*RACE*	*ETHNICITY*
( ) *ENGLISH* ( ) *SPANISH* ( ) *OTHER*___________________	( ) *AMERICAN INDIAN* ( ) *BLACK* ( ) *ASIAN* ( ) *WHITE* ( ) *OTHER* ( ) *DECLINE TO ANSWER*	( ) *HISPANIC* ( ) *NOT HISPANO*

PRIMARY DOCTOR

Name: ____ Phone: ____

Address: ____

PRIMARY INSURANCE	POLICY NUMBER
SECONDARY INSURANCE	POLICY NUMBER

EMERGENCY CONTACT (Name/ Relation to Patient)	PHONE NUMBER

I hereby authorize all insurance benefits to be paid directly to Access Eye Institute, I understand that I am financially responsible for all medical bills, I hereby consent to and authorize the treatment plan, administration of diagnostic and therapeutic that may be considered advisable or necessary in the judgment of Access Eye Institute., I further understand that Access Eye Institute may or may not be contracted with my insurance and it my responsibility to understand my insurance benefits. There is a $25 cancellation fee if a 24- hr. cancellation notice is not given, I understand that by signing this patient information sheet I have read, understood to all of above.

Signature:____Date:________________________

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Medical History Questionnaire

Family History: (M) Mother, (F) Father, (O) Other

____Glaucoma	____Retinal Problems	____Diabetes	____ High Pressure
____Arthritis	____Cancer	____Heart Disease	____Other
____Blindness	____Stroke	____Cataract	

Review of Systems: Do you currently have any problems in the following areas:

	YES	NO	Please Explain
➢ Skin	____	____	______________________________
➢ Ears, Nose, Throat, Mouth	____	____	______________________________
➢ Neck	____	____	______________________________
➢ Respiratory			
o Lungs/Breathing	____	____	______________________________
➢ Cardiovascular			
o Heart/ Blood Pressure	____	____	______________________________
➢ Gastrointestinal			
o Stomach/ Intestines	____	____	______________________________
➢ Genitourinary			
o Kidney/Bladder	____	____	______________________________
➢ Bones/Joints/Muscles	____	____	______________________________
➢ Neurologic			
o Numbness/Migraines	____	____	______________________________
➢ Lymph Nodes Swelling	____	____	______________________________
➢ Allergy (Hay Fever)	____	____	______________________________
➢ Thyroid	____	____	______________________________
➢ Diabetic	____	____	______________________________
➢ Are You Pregnant?	____	____	______________________________

Social History

Do you smoke? Yes____ No____ How Much? ______________________________________

- Do you drink? Yes____ No____ How Much? ______________________________________
- Do you use drugs? Yes____ No____ How Much? ______________________________________

Ophthalmic History

- Have you ever had eye surgery?
  - ____ No
  - ____Yes When_________ Doctor_________ Type________________
- Do you wear glasses?
  - ____ No
  - ____Yes How old is the prescription? ______________
- Have you ever had an eye injury?
  - ____ No
  - ____Yes Please Explain: _________________________________
- Do you have?
  - __Floaters __Tearing __Double Vision __Itching __Burning
  - __Headaches __Pain in Eyes __Nervous Tension ____Glare/ Light Problems

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Name:___________________________________ Date of Birth:______________________

Allergies:____

____

Pharmacy Information

Primary Pharmacy	Secondary Pharmacy
Pharmacy Name: ___________________________________	Pharmacy Name: ___________________________________
Address: ___________________________________ ___________________________________ ___________________________________	Address: ___________________________________ ___________________________________ ___________________________________
Phone Number: ___________________________________	Phone Number: ___________________________________

Medications

☐ See List

Name	Dosage	Reason of intake?

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Access Eye Institute

Our Financial Policy

We are committed to providing you with the best possible medical care. If you have medical insurance, we will try to help you receive your maximum allowable benefits.

Payment for non-covered services and co-pays is due at the time services are rendered. In order to expedite this payment we accept cash, check, and most credit cards.

- Medicare Patients
  - We are participating providers and will bill Medicare for you. You are responsible for your yearly deductible, your co-pay and any non-covered services.

- PPO Patients
  - We are participating providers for most plans and we will bill you insurance company directly. After our office has received payment and all adjustments have been deducted, we will send you a bill for your remaining balance.

- IPA / HMO Patients
  - In order to render services to HMO patients we will need prior authorization by the referring doctor, and will only render services approved by your insurance.

- Please be aware that Medicare and most medical plans do not cover routine eye exams or that portion of the medical eye exam (refraction) that is done to determine your prescription for glasses or contact lens. If you are having this type of examination, you will be responsible for the routine eye exam or the refraction charge unless you have vision insurance in addition to your medical insurance.

Patient Name: ____

Patient Signature: ___________________________ Date: ________________

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Access Eye Institute

Consent for the use of dilating eye drops

Dilating eye drops are used to enlarge the pupils, allowing our physician to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.
Dilating eye drops will usually cause blurred vision. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired as a result, varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving, even in low-light conditions, may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

I ____ (Patient Name) hereby authorize the doctor and/or his ophthalmic assistants to administer dilating eye drops during the course of my treatment.

I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated; or by wearing sunglasses while driving.

Patient (or patient's authorized representative):

____ Date:____________

Witness:

____ Date:____________

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PAUL NAZEMI, M.D.
KHALED TAWANSY, M.D.

199 WEST HILLCREST DRIVE
THOUSAND OAKS, CA 91360
TEL: (805) 497-7976 FAX: (805) 497-7489

PATRICIA BUCKLEY, O.D.
ALEN CHEUNG, O.D.
NEGIN NIKAHD, O.D.

Patient Agreement

I understand and agree that there are multiple providers, ophthalmologist and optometrists, who are part of **Access Eye Institute**, and that the initial and subsequent office visits, procedures, and services provided to me may be rendered by any one of these providers based on **scheduling** and **availability**.

______________________________ ______________________

(Patient Signature) (Date)

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PATRICIA BUCKLEY, O.D.
ALLEN CHEUNG, O.D.
NEGIN NIKAHD, O.D.

HIPAA 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.

This notice of Privacy Practices describes how we use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right 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 or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected your health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected health information will be used, as needed, to obtain payment for your health care services. For example, Obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employment review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmate: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Right

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physicians believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain s paper copy of this notice from us. Up request. Even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy conduct of your complaint**. We will not retaliate against you for filling a complaint.**

This notice was published and became effective on/before **01/01/2016**

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.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name **Patient (or Guardian) Signature** **Date**

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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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron 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 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 if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate 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, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once 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 fails 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, or 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 Effective as of the date of first medical services.

____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of 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.

By: __________________________ __________
Patient's or Patient Representative's Signature (Date)

By: __________________________ __________
Physician's or Authorized Representative's Signature (Date)

By: __________________________
Print Patient's Name

ACCESS EYE INSTITUTE
199 West Hillcrest Drive
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(805) 497-7976 • FAX (805) 497-7489

____
Print or Stamp Name of Physician, Medical Group or Association Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.