Glaucoma Care Center

1401 Avocado Avenue, Suite 302 – Newport Beach, CA 92660
Phone: (949) 288-2382 | Fax: (949) 288-0344

NEW PATIENT REGISTRATION

NAME:

_____

Last *Middle Initial* *First*

DATE OF BIRTH: **GENDER and MARITAL STATUS:** **SOCIAL SECURITY NUMBER:**

_____

ADDRESS:

_____

Number, Street and City *State* *Zip Code*

YOUR CONTACT INFORMATION:

_____

Phone # Cell *Phone # Home* *Preferred # (Cell or Home?)*

_____

Email Address

EMERGENCY CONTACT:

_____

Name *Relationship to You* *Phone #*

PREFERRED PHARMACY

_____

Name *Location* *Phone #*

IMPORTANT- PLEASE READ:

PATIENTS CANCELLING OR RESCHEDULING WITHIN 24 HOURS OF APPOINTMENT OR NOT KEEPING A SCHEDULED APPOINTMENT ("NO-SHOW") WILL BE CHARGED A $100.00 CANCELLATION/RESCHEDULE FEE. FREQUENTLY CANCELED OR RESCHEDULED APPOINTMENTS MAY RESULT IN NO FURTHER APPOINTMENTS BEING SCHEDULED FOR YOU. THIS FEE MAY CHANGE WITHOUT PRIOR NOTICE. Minors must be accompanied by a parent or legal guardian who must complete and sign the paperwork for the minor and attend the exam. Please silence your phone in the waiting area and step outside to take or make calls. _____

Initial Here

Glaucoma Care Center

PATIENT INTAKE

NAME: _____ **DATE OF BIRTH**: _____

DATE OF ENCOUNTER (TODAY): _____

REASON(S) FOR VISIT – CURRENT PROBLEMS: _____

_____

ALLERGIES? _____ *Yes* _____*No* *If yes, what?* _____

ASTHMA? _____*Yes* _____ *No* **DIABETES?** _____*Yes* _____ *No*

LIST YOUR MEDICATIONS:

Medication: _____ How Often and AM or PM? _____

Medication: _____ How Often and AM or PM? _____

Medication: _____ How Often and AM or PM? _____

Medication: _____ How Often and AM or PM? _____

Medication: _____ How Often and AM or PM? _____

PAST MEDICAL HISTORY: _____

_____

PAST SURGICAL HISTORY: _____

_____

FAMILY HISTORY: _____

_____

SOCIAL HISTORY:

Smoker? _____ *Yes* _____ *No* _____ *Past* _____ *How Long?*

Quantity: _____

Alcohol? _____ *Yes* _____ *No* *If yes, how often?* _____

Marital Status: ____ *Married* _____ *Single* _____ *In Partnership* _____ *Divorced* _____ *Other.*

Exercise? _____ *Yes* _____ *No* *If yes, how often?* _____

Recreational Drug use? _____*Yes* _____ *No* *If yes, how often?* _____

STAFF INITIALS and DATE: _____

PRIVACY PRACTICES

Glaucoma Care Center holds all information pertaining to the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. Glaucoma Care Center fully complies with the Federal

The government's mandated HIPAA requirements for patient confidentiality and privacy of healthcare information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstances for which we can disclose protected health information without authorization. Only a patient can provide the authorization to release records necessary for Glaucoma Care Center to disclose protected health information for instances not related to your ongoing treatment and/or payment of claims. A patient may request to view a copy of their medical record in the office or request a copy, for which a fee will be charged.

My "Protected Health Information" means health information, including my demographic information, collected from me, and created or received by my physician: another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment, or health care operations of Glaucoma Care Center. Glaucoma Care Center is not required to agree to restrictions that I may request, however if Glaucoma Care Center agrees to a restriction that I request, the restriction is binding between Glaucoma Care Center and

Name of Patient Signature of Patient Signature Date

CONSENT FOR PURPOSE OF TREATMENT PAYMENT HEALTH CARE OPERATIONS and NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Glaucoma Care Center provided me with a written copy of its Privacy Practices m (this document), which Glaucoma Care Center reserves the right to change and which I have the right to request an updated copy of. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices which explains how my medical information will be used and disclosed and ask questions, prior to signing this document.

I consent to the use or disclosure of my Protected Health Information by Glaucoma Care Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting healthcare operations. I understand that the diagnosis or treatment of me by Glaucoma Care Center, Alena Reznik M.D., Jacob Reznik, M.D. may be conditioned upon my consent as evidenced by my signature on this document.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Relationship (if not patient) Date

I am giving authorization to Glaucoma Care Center to disclose my medical and insurance information to the following:

Person(s) to whom information may be disclosed Relationship (if not patient) Date

Signature of Patient or Personal Representative Date

Print Name of Patient of Personal Representative Relationship (if not patient) Date

Glaucoma Care Center

PAYMENT

Please pay your Co-Pay when you check in at the Front Desk. Self-Pay Patients please pay in full on the day of your visit.

Insurance Patients: We will bill your health insurance provider and then bill you any unpaid balance which could be due to (a) unsatisfied Deductible, (b) Co-Pay due and/or (c) only a portion of the cost was paid by your health insurance carrier (co-insurance or not fully covered).

If you receive a Statement from us, call and we can take your payment over the phone with a credit/debit card, for your convenience. We accept all major credit cards.

Alena Reznik, M.D., Jacob Reznik, M.D., and all Providers of Glaucoma Care Center, have a legal obligation to the insurance companies with which we are contracted, to collect Co-Payments, Deductibles and Co-Insurance where applicable. Once a balance reaches 90 days overdue Glaucoma Care Center may pursue collection or other actions through third parties.

MEDICATIONS

Please bring an updated list of all your current medications (name of drug and dosage) to your visits.

APPOINTMENTS

Hours: Our office is open Monday to Friday, 8:30am to 5:30pm. We are closed for lunch between 12noon and 1:00pm. After hours you may text any urgent concerns or questions to our main phone number.

Please be on time for your appointment. Please confirm your appointment when asked to do so.

CANCELLATIONS / RESCHEDULED APPOINTMENTS

In reserving a specific appointment date and time for you we may have denied it for another patient. You will be charged $100.00 if, within 24 hours of your scheduled appointment time, you cancel or reschedule your appointment. You will be charged $100.00 if you do not keep a scheduled appointment ("No-Show"). This fee may change without prior notice. Frequently canceled or rescheduled appointments may result in no further appointments being scheduled for you.

CONTACT

You may call or text us on our main number. After hours either we, or an "On Call" medical professional, will respond quickly if you have an urgent need. Non-urgent calls/texts will be responded to the next day.

PRESCRIPTIONS

Call or text us with urgent medication refills you may need. If we are busy, leave a message with the name of the drug and the pharmacy phone number, and the issue you have with your prescription (out of refills, low on pill, traveling, etc.). We will address your request as promptly as possible.

_____

Signature of Patient or Patient Representative Date