Completed by Staff: Patient Name:	Medical Record#:

Acuity Eye Group

RetinaInstitute

New Patient Forms

Patient Information			
Name:			DOB (M-D-Y): - -
Address:			
City:	State:	Zip:	SSN: - -
Home Phone: ( ) -	Cell Phone: ( ) -		Work Phone: ( ) -
Sex: [ ] Male [ ] Female	Marital Status:		Email Address:
Emergency Contact Information			
Name:	Relation:		Phone: ( ) -
Doctor / Referral Information			
Primary Care Physician (PCP) :			Phone: ( ) -
Referring Physician (If not PCP):			Phone: ( ) -
Facility Information			
Facility Name:	Skilled Nursing Facility: ☐ Yes ☐ No		Hospice: ☐ Yes ☐ No
Facility Address:			
Financially Responsible Party (If Not Patient)			
Name:			
Address:			
Relation:	DOB (M-D-Y): - -		SSN: - -

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payments for services rendered are due on the same day of service. As part of our services we will submit your insurance claims. Insurance/Financial arrangements should be made with our Patient Relations Department prior to injections, lasers, or surgeries.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION:
I hereby authorize release of any medical information necessary to process my insurance claim and ASSIGN to the DOCTOR all payments from MEDICARE and/or other Insurance provider(s) for services rendered. I understand and agree to the above conditions.

NOTICE OF PRIVACY PRACTICES: I have read the Notice of Privacy Practices and give my consent for disclosure of my medical records related to treatment.

_____ _____
Signature of Patient or Patient Representative Date

_____
Printed Patient Name

_____
Printed Patient Representative Name and Relationship to Patient (If Present)

Acuity Eye Group RetinaInstitute

PHYSICIANS – 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 be a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in 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 binds all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born 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 both 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 parties, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated 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 not supplant, any other applicable statutory of common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and the joinder in this arbitration of any persons 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement 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 one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if assessed 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 of signature. It is the intent of this agreement to apply to all medical services rendered any time for the condition.

Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (Including, but not limited to, emergency treatment) the patient should initial directly below and this agreement will be considered effective as of the date of the first medical services:

_____Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or 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 TO COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Patient Name

_____

Printed Patient Representative Name and Relationship to Patient (If Present)

_____ _____

Signature of Physician or Authorized Representative Date

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NOTICE OF PRIVACY PRACTICES

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive. We need this record to provide you with quality of care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this company.
THIS NOITCE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However; all the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment: We will use medical information to provide for your medical care. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide.
2. Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
3. Payment: We will use medical information to obtain payment for the services we provide.
4. Healthcare Operations: We may use medical information to operate our medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the quality and competence of our professional staff.
5. Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. We will not provide any medical information when leaving messages.
6. Sign-in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
7. Email: We may contact you via email.
8. Marketing: We may contact you to give you information about products and services related to your treatment, case management, or care coordination.
9. Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. We may at times be required to disclose your health information to a law enforcement official for purposes of identifying or locating a suspect fugitive, material witness, or missing person.
10. Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information during administrative or judicial proceedings to the extent expressly authorized by a court or administrative order.
11. Public Health: We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: Preventing or controlling disease, injury or disability; Reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the FDA problems with products, reactions to medications, and reporting disease or infection exposure.
12. Food and Drug Administration (FDA). We may disclose health information about you (applicable to study patients only) to the FDA, or to an entity regulated by the FDA in order, for example, to report an adverse event or a defect related to a drug or medical device.

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OTHER USES OF MEDICAL INFORMATION:
Other uses and disclosure of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. This notice will contain the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Retina Institute of California or Acuity Eye Specialists via mail or email the Privacy Officer at PrivacyOfficer@retina2020.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

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 your vision will be affected. Because driving may be difficult immediately after an examination, it is best to plan beforehand to avoid driving afterwards.

Adverse reactions, 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 the doctor I am visiting and any assistants designated by him/her to administer dilating eye drops. I understand that dilating eye drops are necessary to diagnose my condition.

_____ _____
Signature of Patient or Patient Representative Date

_____
Printed Patient Name

_____
Printed Patient Representative Name and Relationship to Patient (If Present)

Acuity Eye Group

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OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure and what services are covered.
4. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
6. Co-payments are due at time of service. A processing fee (or service fee) will be charged in addition to your co-payment if the co-payment is not paid at the time of service or by the end of the next business day.
7. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
8. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
9. I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Patient Name

_____

Printed Patient Representative Name and Relationship to Patient (If Present)

Acuity Eye Group RetinaInstitute

NOTICE OF INSURANCE/CO-PAY DIFFERENCE

I acknowledge that if my insurance does not cover the services that I receive, I will be responsible for paying for the services that I have received. I understand that it is my responsibility to notify the Retina Institute of California (RIC) or Acuity Eye Specialists (AES) of any changes to my insurance. I understand that if I do not notify RIC or AES of any changes to my insurance, I will be held responsible for the services performed and will receive a bill by mail. I understand that if my insurance does not pay the full balance for the services that I have received, that I will be responsible for any remaining balance or co-pay amount.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Patient Name

_____

Printed Patient Representative Name and Relationship to Patient (If Present)

CANCELLATION POLICY

Please understand that we set aside time for each patient. If you do not call to cancel your appointment within at least 24 hours' notice, you may be subject to a $25 cancellation fee. Thank you for your cooperation.

I have read and understand this office cancellation policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Patient Name

_____

Printed Patient Representative Name and Relationship to Patient (If Present)

Completed by Staff: Patient Name:	Medical Record#:

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PATIENT MEDICAL HISTORY

MEDICATIONS, ALLERGIES, SURGERIES	
Drug Allergies? [ ] YES [ ] NO	Surgeries? [ ] YES [ ] NO
If YES to Drug Allergies, list all medications and reactions in the space provided below. (EX: Penicillin, Sulfa Drugs, NSAIDs, etc.)	If YES to Surgeries, list all surgeries below. (EG: Tonsillectomy, Appendectomy, Cataract, etc.)

PAST MEDICAL HISTORY	
Have you ever been hospitalized? [ ] YES, please specify date and reason below. [ ] NO	
Date	Reason

Have you been diagnosed with any of the following conditions? (Check any that apply)

☐ Anemia	☐ Goiter	☐ Kidney stones
☐ Angina	☐ Heart murmur	☐ Leukemia
☐ Asthma	☐ Heart Problems	☐ Pneumonia
☐ Cancer (specify below)	☐ Hepatitis	☐ Psoriasis
☐ Cataracts	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Colitis	☐ High Cholesterol	☐ Rheumatic Fever
☐ Crohn's Disease	☐ HIV/AIDS	☐ Stomach or Peptic Ulcer
☐ Diabetes	☐ Hypothyroidism	☐ Stroke
☐ Emphysema	☐ Jaundice	☐ Tuberculosis
☐ Epilepsy (seizures)	☐ Kidney disease	

Other Medical Conditions:

SOCIAL HISTORY

(Check any that apply)

☐ Smoking, _____ packs per day, for _____ years.
☐ Alcohol
☐ Illicit Drugs, specify: _____, _____, _____, _____

Completed by Staff: Patient Name: Medical Record#:

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GENERAL PROBLEM REVIEW

In the past month, have you had any of the following problems? (Check any that apply)

General
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night Sweats

Muscle/Joints/Bones
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of Vision
- ☐ Double/Blurred Vision
- ☐ Dryness

Throat
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

Heart and Lungs
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs/feet
- ☐ Cough

Skin
- ☐ Redness
- ☐ Rash
- ☐ Nodules/Bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

Stomach and Intestines
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow Jaundice
- ☐ Constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

Nervous System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting/Loss of Consciousness
- ☐ Numbness or Tingling
  Memory Loss

Ears
- ☐ Ringing in ears
- ☐ Loss of hearing

Blood
- ☐ Anemia
- ☐ Clots

Kidney/Genital/Bladder
- ☐ Frequent/Painful urination
- ☐ Blood in urine
- ☐ Impotence
- ☐ Incontinence
- ☐ Infections

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Insomnia
- ☐ Hallucinations
- ☐ Disorientation

FAMILY HISTORY

Has a member of your family been diagnosed with any of the following problems? (Check any that apply)

Father
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Mother
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Brother
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Sister
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Daughter
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☑ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Son
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Other: _____

Please send your completed New Patient Packet to
hello@acuityeyegroup.com