East Bay Ophthalmology, Inc. **Dr. Scott E. Lee**

Patient Consent Form

Privacy Rule (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provided the minimum necessary information to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our patients), to request and revoke consent in writing.

Consent for Photographs and Videos

I give permission for the East Bay Ophthalmology to take photographs and/or videos for medical treatment, insurance authorization, educational purposes, or any other purposes in the necessary work of the organization.

Consent for Medication History

I give permission for the East Bay Ophthalmology to obtain medication history for clinical use only.

Consent for Refraction

Refraction is a procedure that determines the prescription for eyeglasses or contact lenses. We can bill your insurance for this procedure, but if it is denied, I understand that I am responsible for the **$50.00** cost of this procedure. I understand that I can choose not to be refracted as well.

Consent to Cancellation Fee

I understand that I am responsible for a $20 fee for appointments cancelled or rescheduled within 24 hours.

Consent for Insurance Authorization

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Dr. Lee for any services furnished to me by them. I authorize any holder of medical information about me to release to the health care financing administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Consent for Financial Responsibility

I understand that I am financially responsible for all charges whether or not paid by the insurance. I understand that any claims that are denied or left unpaid after 3 months will be patient responsibility and any patient with recurring denials will be considered cash payment upfront and will be reimbursed if and when the insurance pays.

Your signature below acknowledges your understanding of the Privacy Rule, Consent for Photographs and Videos, Consent for Refraction, Consent for Medication History and Consent for Financial Responsibility.

_____ _____

Print Name Date

_____

Signature

NAME:_____

East Bay Ophthalmology
1289 Pinole Valley Road
Pinole, CA 94564
(510) 724-1768

Past Eye History

- ☐ None
- ☐ Cataract of Right Eye
- ☐ Cataract of Left Eye
- ☐ Glaucoma
- ☐ Eye Injury
- ☐ Amblyopia (Lazy Eye)
- ☐ Retinal Detachment
- ☐ Macular Degeneration

Other: _____

Past Eye Surgery

- ☐ None
- ☐ Cataract Extraction of Right Eye
- ☐ Cataract Extraction of Left Eye

Other: _____

_____

_____

_____

_____

Eye Drops

- ☐ None
- ☐ Latanoprost
- ☐ Alphagan
- ☐ Lumigan
- ☐ Xalatan
- ☐ Travatan Z
- ☐ Brimonidine
- ☐ Dorzolamide
- ☐ Timolol
- ☐ Cosopt
- ☐ Combigan
- ☐ Simbrinza
- ☐ Azopt
- ☐ Artificial Tears
- ☐ Betagan
- ☐ Betopic S
- ☐ Betimol
- ☐ Diamox
- ☐ Patanol
- ☐ Propine
- ☐ Pilocarpine
- ☐ Timoptic
- ☐ Trusopt
- ☐ Zaditor
- ☐ Other _____

_____

Past Laser Procedure

- ☐ None
- ☐ YAG RIGHT eye LEFT eye
- ☐ PI RIGHT eye LEFT eye
- ☐ LASIK RIGHT eye LEFT eye
- ☐ SLT RIGHT eye LEFT eye
- ☐ Ambulatory RIGHT eye LEFT eye

Social History

Do you Smoke?	Y	N
Are you a former smoker?	Y	N
Do you drink Alcohol?	Y	N
Do you do any drugs?	Y	N

Eye Related Information

Are you taking **FLOMAX?**	Y	N
Do you have **DIABETES?**	Y	N
Do you have **HIGH BLOOD PRESSURE**?	Y	N
Do you have **THYROID DISEASE?**	Y	N

Family Eye History

- ☐ Blindness
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other_____

What is your **OCCUPATION**?
If retired, what was your occupation? _____

Name of Primary Care Doctor: _____

General Medical History

Please CHECK if you have or had these symptoms in the past:

General
- ☐ Fever
- ☐ Fainting
- ☐ Cancer _____
- ☐ Hepatitis
- ☐ Pregnant
- ☐ Allergies

Skin
- ☐ Rash

HEENT
- ☐ Ear
- ☐ Nose
- ☐ Throat

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Stroke
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Anemia
- ☐ Bleeding tendency

Respiratory
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Bronchitis

Gastrointestinal
- ☐ Stomach
- ☐ Liver
- ☐ Colon

Urinary
- ☐ Kidney disease
- ☐ Bladder
- ☐ Dialysis

Musculoskeletal
- ☐ Arthritis
- ☐ Joint pain
- ☐ Muscle pain

Endocrine
- ☐ Diabetes
- ☐ Weight loss
- ☐ Thyroid issue

Psychological
- ☐ Depression
- ☐ Anxiety

Neurological
- ☐ Headaches
- ☐ Memory loss

Breast

_____

Genital

_____

Other

_____
_____
_____
_____
_____
_____
_____
_____

Surgery

_____
_____
_____
_____

Current medications

_____
_____
_____
_____

Allergies to Medicine

_____
_____
_____
_____

Family History

Please CHECK any disease which occur in your family

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Cancer
- ☐ Heart attack
- ☐ Stroke

EAST BAY OPHTHALMOLOGY

Patient Demographics

First Name_____

Middle Name _____

Last Name_____
Suffix_____
Home #_____
Cell #_____
Email_____
Social Security # _____
Date of birth_____
Sex_____
Race_____
Ethnicity_____
Marital Status _____
Preferred Language _____
Referred By_____

Country_____
Street Address_____
Zip Code_____
City_____
State_____
Emerg Cont Name _____
Emerg Cont Phone _____
Emerg Cont Relation _____
Resp Party Name _____
Resp Party DOB _____
Resp Party Relation _____
Resp Party Phone _____
Resp Party Email_____