



Comprehensive Eye Care Specialists

Welcome! Thank you for scheduling an appointment with Allaman Eye Care & Associates.

Your check-in time for your appointment with _____ is scheduled for:

_____ AT _____

at ☐ 1665 Dominican Way, **Suite 122** ☐ 1667 Dominican Way, **Suite 130**

Kindly have all paperwork filled out prior to your arrival to avoid delays

We look forward to caring for you. Allaman Eye Care & Associates is a full service ophthalmology office specializing in general ophthalmology, glaucoma management, diabetic eye care management, retinal examinations, dry eye treatment, state of the art vision correction and cataract surgery using the latest generation intraocular lenses for correcting presbyopia, myopia, hyperopia and astigmatism, contact lens fittings with our optometrists, and an onsite, full service optical department. Please visit our website at www.allamaneyecare.com.

Please bring your insurance cards, co-payment, completed patient registration and history forms, any glasses you are currently using (including non-prescriptive near vision glasses.) and a list of ALL medications you are currently taking. You should prepare for the possibility of having your eyes dilated at this visit by bringing dark glasses with you to this appointment.

Most appointments will take a little over one hour. For surgical evaluations, the appointment may take two to three hours.

If you are unable to attend your appointment as scheduled, please provide us with 24 hour notice and we will be happy to reschedule your appointment to a time that will be more convenient for you.

Again, thank you!

THE STAFF OF ALLAMAN EYE CARE & ASSOCIATES

ALLAMAN EYE CARE & ASSOCIATES

PATIENT REGISTRATION FORM

TODAY'S DATE: _____

Patient Name: _____ Contact Phone: () _____

EMAIL Address: _____ Cell or Alternate Phone: () _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Sex: M / F Date of Birth: _____ / _____ / _____ SS # _____ - _____ - _____

Occupation: _____ If retired, previous occupation(s) _____

Employer: _____ Work Phone: () _____

Hobbies/Sports _____

Patient's Primary Physician _____ Name of Specialists _____

Were you referred to our practice? Y / N Referring Doctor or Refer Source _____

Person to Notify in the Event of an Emergency: _____

Relationship: _____ Phone: () _____

Primary Medical Insurance: _____ Is your insurance an HMO? Y / N

Secondary Medical Insurance: _____ Co-Payment Amount: \$ _____

Vision Insurance: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ / _____ / _____ Subscriber SS # _____ - _____ - _____

****PLEASE PROVIDE YOUR INSURANCE CARD TO OUR RECEPTIONIST****

Person Responsible for Billing, if other than Patient: _____

Date of Birth: _____ / _____ / _____ SS # _____ - _____ - _____

Address: _____ Contact Phone: () _____

Relationship to Patient: _____

**** IF YOU ARE CURRENTLY ON HOSPICE CARE, PLEASE INFORM THE FRONT DESK ****



LIFETIME AUTHORIZATION OF INSURANCE BENEFITS AND BILLING INFORMATION FOR ALL PATIENTS

Thank you for choosing Allaman Eye Care. **Because insurance companies change their carriers, plans and benefits frequently, it is difficult for us to verify that your insurance plan is one that we are contracted with at the time of your visit. You are encouraged to verify your benefits and whether our doctors are contracted with your plan PRIOR to your visit.** We will bill your insurance as a courtesy service, but **it is your responsibility to be up to date on your insurance plan and its requirements, covered physicians, covered services, deductibles and copayment amounts.** Regardless, you will be seen by our doctors as we do not want to withhold services inappropriately. Providing services or making a copy of your insurance card **DOES NOT** confirm that you have coverage with us. If we do not contract with your insurance company, you may request a statement that outlines all necessary information required for reimbursement. _____ **Initials**

REFRACTIONS:

Refractions are performed to determine a patient's visual acuity. Most insurance companies **DO NOT COVER REFRACTIVE SERVICES.** Allaman Eye Care agrees to bill my refractive service to my insurance, but **DOES NOT** guarantee that the service will be covered. If refractive services are not covered by my plan, I agree to be responsible for the charges. _____ **Initials**

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to Allaman Eye Care for any services furnished to me. I authorize Allaman Eye Care to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand that Allaman Eye Care has agreed to accept the allowed charge determined by Medicare as full charge. Medicare pays 80% of that charge and I understand that I am responsible for the balance of the charge, co-insurance and non-covered services. Co-insurance and deductibles are determined by the carrier. I understand that Medicare excludes all refractive services from their coverage. I agree to be personally and fully responsible for the refractive portion of my eye exam. Medicare (and most other insurance carriers) does not cover eyeglasses or medications, in most cases. If other health insurance coverage is indicated (secondary insurance), my signature authorizes release of the information to the insurer or agency.

HMO/PRIOR AUTHORIZATION PATIENTS:

_____ **Initials**
I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Allaman Eye Care. If for **ANY** reason, a service is not authorized or denied, I assume full responsibility for any and all charges, including copayments and deductibles.

Allaman Eye Care and our doctors are contracted with Dignity Health Medical Network (DHMN), formerly Physician's Medical Group (PMG) of Santa Cruz.

We are NOT providers for the Palo Alto Medical Foundation (PAMF) HMO or Kaiser Permanente HMO.

PRIVATE PAY PATIENTS: Payment for services rendered **is required at the time of service.** We offer a 10% discount as a courtesy for your payment. If at any time in the future, you become insured with medical or vision coverage, please let our staff know.

We are committed to providing quality service. With the constant changes in the healthcare arena, this can be a consuming process. Thank you in advance for your cooperation.

ALLAMAN EYE CARE & ASSOCIATES

I have read the above information. I understand that it is my responsibility to know whether Allaman Eye Care is a provider for my insurance plan. I request that payment of insurance benefits be made on my behalf to Allaman Eye Care for any services furnished to me by their physicians and suppliers and authorize any medical information necessary to ensure payment.

I understand that all charges for services rendered to me are ultimately my financial responsibility. Should I receive services and Allaman Eye Care IS NOT a contracted provider, or if the service rendered is not a covered benefit under my plan, I agree to be financially responsible and will pay in full for all such charges.

Patient (Responsible Party) Signature

Date



RELEASE OF MEDICAL RECORDS AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below.

I, _____ (DOB: ____/____/____), hereby authorize the
optometrist/ophthalmologist listed below to release my medical records:

From: Dr.'s Name: _____

Address: _____

Phone: _____

Fax: _____

**To: Allaman Eye Care
Christen Allaman, MD
1665 Dominican Way, Suite 122
Santa Cruz, CA 95065
Ph: 831-476-1298
Fax: 831-476-9468**

****** Please include the following information: Chart Notes, Surgical Information (including type of surgery, eye and dates, IOL model and power), refractive information, pre-op biometry, refraction, keratometry, white to white, axial length (A-Scan & IOL Master), visual field testing, OCT's, HRT's, and Photos. ******

Other: _____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of healthcare information are prohibited from re-disclosing it except as specifically required or permitted by law.

Signature: _____ Date: _____

Relationship if other than patient: _____

Confidentiality Note: This fax is intended for person or entity to which it is addressed and may contain information which is privileged, confidential or otherwise protected from disclosure. Dissemination, distribution or copying of this fax or the information herein by anyone other than the intended recipient is prohibited. If you have received this fax in error, please notify the sender by reply fax to (831) 476-9468 and destroy the original message and all copies. Thank you.



MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Date: _____

List any **MEDICAL** conditions you have (diabetes, high blood pressure, arthritis, thyroid problems, etc.):

List any **NON-EYE RELATED SURGERIES** you have had and when (bypass, thyroid, cancer, etc.):

List any **RX & NON-RX MEDICATIONS and VITAMINS** you take (If none, list "none") or provide list:

List any **MEDICATION ALLERGIES** and the type of reaction you have (If none, list "none"):

List any **EYE** conditions you have (e.g. cataracts, macular degeneration, glaucoma, retinal problems, etc.):

List any **EYE SURGERIES OR INJURIES** you have had and when (cataract, LASIK, trauma etc.):

FAMILY HISTORY: (Mother, Father, Grandparents, Siblings)

Have any of your blood relatives had any of the following conditions (if so, who)?

Diabetes _____	Thyroid Disease _____	Cancer _____
Arthritis _____	Heart Disease _____	High Blood Pressure _____
Stroke _____	Glaucoma _____	Macular Degeneration _____
Retinal Problems _____	Cataracts _____	Lazy Eye _____
Color Blindness _____	other heritable disease _____	

SOCIAL HISTORY:

Do you smoke? YES/NO If YES, how much? _____ How many years? _____
Do you drink alcohol? YES/NO If YES, how much? _____
Do you drink caffeine? YES/NO If YES, how much? _____
Have you ever had a blood transfusion? YES/NO _____

Does your vision limit any activities of daily living? (Driving, reading, sports, work etc.)
YES/NO _____

Who is your Primary Care Physician? _____
Do you see any specialists? If YES, list: _____
Date of last eye exam: _____
Do you wear glasses? YES/NO If YES, for what? _____
Do you wear contact lenses? YES/NO If YES, what type/brand? _____

Do you have **ANY** problems in the following areas? If YES, please explain:

General/Constitutional (fever, weight loss/gain, fatigue)	YES/NO _____
Ear/Nose/Throat (hearing loss, sinus problems, allergies)	YES/NO _____
Cardiovascular (chest pain, irregular heartbeat, angina)	YES/NO _____
Respiratory (asthma, wheezing, COPD, bronchitis)	YES/NO _____
Gastrointestinal (heartburn, diarrhea, ulcers, abdominal pain)	YES/NO _____
Genitourinary (pain/discomfort, bladder infections, prostate)	YES/NO _____
Skin (rashes, eczema, dermatitis)	YES/NO _____
Musculoskeletal (arthritis, joint pain/swelling, stiffness)	YES/NO _____
Neurological (numbness, headaches, seizures, weakness)	YES/NO _____
Blood/Lymph (bleeding, anemia, clotting disorders)	YES/NO _____
Endocrine (hyperthyroid, hypothyroid, diabetes)	YES/NO _____
Psychiatric (depression, anxiety, insomnia)	YES/NO _____
Immunological (lupus, rheumatoid arthritis)	YES/NO _____
Cancer (skin or other)	YES/NO _____
Females: are you pregnant? Nursing?	YES/NO _____

Other important information:

Signature of Patient or Parent/Guardian: _____ Date _____



REFRACTIONS

A **refraction** is done to determine whether you are nearsighted, farsighted, have astigmatism and determines how well you can see. It also determines whether glasses are necessary or if a glasses prescription needs to be changed. This is a very important part of a complete eye examination. If your vision cannot be corrected with glasses, you may have some form of eye disease.

Although we feel a refraction is important, **Medicare** and most health insurance companies will not pay for this service. **The fee for refractive service in our office is \$80.00.** If you have vision insurance, such as Vision Service Plan (VSP) or Medical Eye Service (MES), most of this charge may be covered. Remember, vision insurance is designed to cover basic eye examinations for refractive errors, (myopia- nearsightedness, hyperopia-farsighted, astigmatism, or presbyopia – reading glasses over age 40). Medical insurance is designed to cover medical eye conditions (amblyopia, strabismus, cataracts, glaucoma, etc.)

Ideally, a complete eye examination should include refraction, especially if you cannot see well, and we do feel it is needed. However, it may be possible for us to perform an eye examination in order to be sure you have no serious eye disease without performing a refraction. Because we do not wish to present you with “hidden” charges, we will only perform refractive services with your permission.

Special notice for CCAH/Medi-Cal Patients: Your insurance may include refractive services covered by vision insurance; however, we may not be providers under that plan. You can obtain the names of participating vision providers from your insurance manual. Should you wish to receive refractive services with our office, you will be required to pay the fee. _____ (please initial)

Please sign this statement to indicate that you have read and understand the purpose of refractions and you understand you are financially responsible if your insurance company denies payment for this service. Insurance

Patient's Signature

Print Patient Name

Date of Service

Eye Care Medical Group

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION.

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

“Protected Health Information” is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We maintain and share health and financial related records about you in both paper and electronic form. We use this information and disclose it to others for the following purposes:

Treatment. We use your health information to provide health care to you and to coordinate your health care with other providers, and we disclose it to other health care providers electronically to enable them to provide health care services to you. For example, if we refer you to a specialist physician we send all or a part of your health record to the specialist to assist him or her in evaluating and treating you. If your provider is a Participant of a Health Information Exchange your records will be visible to other providers that are Participants in the Exchange.

Payment. We use and disclose your health information to obtain payment for health care services we provide to you, including determining your eligibility for benefits. For example, we may send a claim to your insurer that contains information about the services we provided to you, or we may send a bill to a family member who is responsible for paying for your care.

Health care operations. We use and disclose your health information as necessary to enable us to operate our medical practice. For example, we use our patients' claims information for our internal financial accounting activities, and we review health records to ensure quality.

We also disclose health information to our Business Associates who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures for payment or operational purposes. For example, companies that provide or maintain our computer systems may have access to computerized health information in the course of providing services to us.

Contacting you. We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care. Unless you object, we may disclose medical information to a friend or family member who is involved in your care, to the extent we judge necessary for their participation.

Other Disclosures. We may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Here are the general kinds of disclosures we may be required or allowed to make without your authorization:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or to other persons in connection with public health activities
- We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- Disclosures to agencies responsible for overseeing the health care system, for audits, inspections or investigations
- Disclosures for judicial and administrative proceedings, such as lawsuits
- Disclosures to law enforcement agencies
- Disclosures to coroners and medical examiners
- Disclosures to organ procurement agencies, if you are an organ donor or a possible donor
- Disclosures to researchers conducting research under the auspices of an Institutional Review Board or privacy board
- Disclosures to avert a serious threat to health or safety

- If you are a member of the armed forces or a veteran, we may release health information to your military command authority or to the veterans' administration to assist in determining your eligibility for veterans' benefit. Disclosures to assist authorized federal officials in national security activities, or for the provision of protective services to officials
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the institution or official
- Disclosures to other agencies administering government health benefit programs, as authorized or required by law
- Disclosures to comply with workers' compensation laws.
- We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- Disclosures to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Limitations. In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of health information for purposes unrelated to the program. In addition, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Authorization. Except as described above, we will not permit other uses and disclosures of your health information without your written authorization, which you may revoke at any time in the manner described in our authorization form.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- You have the right to ask us to restrict certain uses and disclosures of your health information. However, we are not required to agree to any restrictions requested by our patients.
- You have the right to receive confidential communications from us, for example by asking us to contact you at a particular telephone number, post office box or other address.
- You have the right to inspect and copy any certain records that we maintain. These include our medical records and billing records concerning you. Under certain circumstances, we may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.
- If you feel the information in our records is wrong, you have the right to request us to amend the records. We may deny your request in certain circumstances. If your request is denied, you have the right to submit a statement for inclusion in the record.
- You have the right to receive a report of non-routine disclosures that we have made of your health information, up to six years prior from the date of your request. There are some exceptions: for example, we do not maintain records of disclosures made with your authorization; disclosures made for the purposes of treatment, obtaining payment for health services, or operating our medical practice; disclosures made to you; and certain other disclosures.
- You have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity for any record we maintain in electronic format. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with sending (electronic or hard copy) your medical record.
- You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- If you received this notice electronically, you have the right to request a paper copy from us at any time.
- You have the right to opt-out of the Health Information Exchange. Your physician can provide you with more information or visit www.santacruzhi.org.

The foregoing is a general statement of your rights. They are subject to all limitations permitted or required by law.

How do I exercise these rights? You can exercise any of your rights by sending a written request to our Privacy Official at the address below. We encourage you to call our office and speak to us if you have any questions or concerns. Susan Blackwell, Eye Care Medical Group, 1665 Dominican Way, Santa Cruz, CA 95065, 831-476-1298.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR
EYE CARE MEDICAL GROUP

SIGNATURE

Date: _____ Time: _____ a.m./p.m.

Printed Name: _____

Signature: _____
(Patient/ Representative/ Spouse/ Financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:
