CORNEA EYE INSTITUTE

DATE :

FOR INSURANCE PURPOSES PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	M.I.	HOME PHONE
ADDRESS			WORK PHONE
CITY	STATE	ZIP CODE	CELL PHONE
DATE OF BIRTH / AGE / SEX M F / MARITAL STATUS M S D W			E-MAIL ADDRESS
PATIENT'S EMPLOYER	OCCUPATION		SOCIAL SECURITY
EMPLOYER ADDRESS			DRIVER'S LICENSE
FOR INSURANCE PURPOSES PLEASE PROVIDE REFERRING PHYSICIAN, OTHER OR SELF			
PLEASE CIRCLE ANY OTHER ONLINE SOURCES: YAHOO GOOGLE LA TIMES YELP WEBSITE			

SPOUSE NAME	WORK PHONE	OCCUPATION	
COMPANY NAME			
ADDRESS		CITY	ZIP CODE

PATIENT INSURANCE INFORMATION (MUST BE COMPLETED)	
PRIMARY INSURANCE COMPANY	SUBSCRIBER
ADDRESS	CERTIFICATE
CITY, ST., ZIP	GROUP # OR NAME
PHONE NUMBER ( )	RELATIONSHIP
SECONDARY INSURANCE COMPANY	SUBSCRIBER
ADDRESS CITY, ST., ZIP	CERTIFICATE #
IF USING VSP PLEASE CIRCLE HERE: YES NO	GROUP # OR NAME
	RELATIONSHIP

NAME OF NEAREST RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)	
NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the above named doctor to furnish information to insurance carriers on my behalf concerning my illness, and hereby irrevocably assign the doctor all payments for medical services rendered. I understood that I am financially responsible for all charges not covered by my insurance

PATIENT'S SIGNATURE_____

INSURED'S SIGNATURE_____

Billing Policy - Cornea Eye Institute

Please read this document carefully and sign below

1. **If you are age 65 or older and/or have Medicare** - we are Medicare providers and as such we accept your insurance, Medicare dictates the payment schedule for services covered under Medicare. You are still responsible for what Medicare does not pay which is usually 20% of what they allow. If you have a secondary insurance this will usually cover the 20% and you will be responsible for your deductibles or any co-pays only, which will be due at time of service.

2. **If you are under 65 and have a private insurance** (i.e. PPO or POS)- we accept all private insurance's but we are only providers for Medicare, Medi-cal and VSP (non-surgical). For the plans for which we are providers we will accept their fee schedule. For all other insurance there is a minimum charge of $295 for a new cornea consultation and $145 for all follow up corneal visits. For an Adult Cornea Transplant the minimum fee is $4,900 (includes 90 day post-operative care) and for a Pediatric Cornea Transplant the minimum fee is $8,000 (Includes 90-day post-operative).

3. Your private insurance will in most instances cover most of these charges, but you will be responsible for the difference between our minimum charge and what your insurance company allows. Payments for services are normally due at the time of service. If we are not providers for your private insurance the minimum fee is due at the time of service.

4. **If you have no insurance**- the following are our charges: $295 for a Cornea Consultation, $295 for a consultation to rule out Keratoconus, $395 Cornea Consult for any child under ten years old, $4,900 for an Adult Cornea Transplant (with no other associated procedures) and $8,000 for a Pediatric Cornea Transplant (with no other associated procedures). Payments for services are normally due at time of service.

5. **Refractive Consultation (i.e. LASIK)** - consultations are complimentary only to those who have not had prior refractive surgery.

6. **INTACS**- $4900.00 per eye, which includes 90 days of post-operative care related to the procedure.

7. **Collagen Cross-Linking (i.e.CXL)**-$4900.00 per eye, which includes facility fee and follow up visits pertaining to CXL procedure.

8. **Initial consultation fee** is not applicable to any surgical procedure.

If you have any questions or require any clarification of these policies, please feel free to discuss this with one of the receptionists.

I have read and understand the billing policies above and as a patient of this practice I agree to abide by them.

Patient Name_____

Patient Signature_____ Date_____

Medical History

PLEASE PRINT

Name_____ Date _____

What concern if any do you have about your eyes?_____

_____

Have you ever had eye surgery? _____ Yes _____ No

If yes, please describe_____

Have you ever had an eye injury _____ Yes _____ No

If yes, please describe _____

List all: Medications _____ _____
(Use other side if necessary) _____ _____

Allergies: _____ _____

Do you or any blood relatives have any of the following: **Mark "S" for Self, "R" for relative**

_____Heart Disease	_____Blindness	_____Macular Degeration	_____HIV Positive
_____Glaucoma	_____Retinal Detachment	_____Diabetes	
_____Stroke	_____High Cholesterol	_____Arthritis	
_____Cancer	_____High Blood Pressure	_____Thyroid Disease	

_____Other (Please List) _____

_____

Please list all surgical procedures you have had in the past: _____

_____

Do you have an Optometrist? _____ Yes _____ No If yes please list: _____

Do you wear glasses or contact lenses? _____ Yes _____ No If so, for how long? _____

Do you smoke? _____Yes _____ No

Do you use alcohol? _____ Yes _____ No If yes, how often? _____

Are you pregnant? _____ Yes _____ No Height:_____ Weight:_____ (For Surgery Purposes)

_____

Signature of Patient or Guardian Date

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to court or administrative order.

3. If required to so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if requires by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement official if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment
are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Cornea Eye Institute 50 N. La Cienega Blvd., Suite 340, Beverly Hills, CA 90211.**

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Cornea Eye Institute 50 N. La Cienega Blvd., Suite 340, Beverly Hills, CA 90211**. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Cornea Eye Institute at (310) 248-7474**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the **Cornea Eye Institute at (310) 248-7474**.

I hereby acknowledge that I have been presented with a copy of the Cornea Eye Institute's Notice of Privacy Practices.

Name of Patient_____
Print

Signature_____

Date_____

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 of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right 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 bind all parties whose claims may arise out of or relate to treatment or services 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 partners, 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 or not 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 part 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 thereafter. Each party to the arbitration shall pay such party's pro rata share or 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.

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 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 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 judgment or summary adjudication in accordance with the Code of Civil Procedure.

TURN OVER FOR PAGE 2 **Patient Initials**_____

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 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 arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitrations.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____
Patient's or Patient's 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 OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____ Date
Physician's or Duly Authorized Representative's Signature

By:_____
Patients Signature Date

_____
Print Patient's Name

_____
Print or stamp Name of Physician

By:_____
Patient's Witness Signature Date

By: _____
Signature of Translator (if applicable)Date

_____
Print Name and Relationship to Patient

_____
Print Name of Translator