DLP EYE GROUP

A Covenant Physician Partner

Patient Demographic Form

Personal Information:

Last Name: ______________________ First: ________________________ Middle: ____________________

DOB(M-D-Y):___________________ Address: ____

City: _____________________________________ State: __________ Zip Code: ____________________

Home Phone: (_____) _______________________ Cell Phone: (_____) _________________________

Email: ____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ________________________ SSN: ___________________________

Preferred Method of Communication: ☐ Email ☐ Phone ☐ Letter

Medical Insurance Information:

☐ Medi-Cal ☐ Medicare ☐ Private ☐ Cash

Insurance Name: ____________________________ Secondary Insurance: _______________________

Primary on Insurance: ☐ Self ☐ Other (Please specify below)

Member ID: ______________________________ Policy/Group Number: _______________________

Responsible Party / Primary Subscriber (if other than patient):

☐ Guardian ☐ Spouse ☐ Power of Attorney ☐ Other: ___________________

Last Name: _______________________ First Name: __________________________

DOB (M-D-Y): ________________________ SSN: _________________________

Address (if different than patient's): ____

City: ___________________________________ State: ________ Zip Code: _______________

Emergency Contact:

Name: ____________________________________ Phone: _________________________________

Certification:

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Patient Signature: ____Date: ________________________

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Patient MRN#______________

Medical History

Date: ____________________________
DOB: ____________________________

Patient Name: ____________________________ Patient Phone#: ______________________
PCP (Primary Care Physician): ____________________________ Phone # ____________________________
Pharmacy Name & Location ____________________________ Phone # ____________________________

MEDICAL HISTORY

(Circle any that apply)

Diabetes
High blood pressure
Low blood pressure
Congestive heart failure
Stroke (CVA)
Rheumatoid arthritis
Sjogren's syndrome
Cancer
HIV/AIDS
Hepatitis
Breathing disorder/lung disease
Kidney disease or disorder
Thyroid disease or disorder
Heart disease or disorder
Migraines
Bleeding disorders
Raynaud's disease
History of steroid use
Other____________________

OCULAR HISTORY

(Circle any that apply)

Cataracts
Glaucoma
Retinal detachment
Trauma
Muscle disorder (Strabismus)
Lazy eye (Amblyopia)
Ocular migraines
Uveitis
Droopy eyelids
Cornea disorder
Dry eyes

VISION CORRECTION (circle)

Glasses Contact lenses

PEDIATRIC

	Yes	No
Born full term		
Reaching developmental milestones		

SURGICAL HISTORY (including eyes)

____
____
____
____
____
____
____

FAMILY HISTORY

	Yes	No	Relation
Glaucoma			
Cancer			
Blindness			
Macular degeneration			
Diabetes			
Retinal detachment			
High blood pressure			
Stroke			

ALLERGIES

____
____
____
____
____
____

MEDICATION (including dosages, frequency)

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

if you need additional space, continue on the back of paper.

Have you experienced any of the following changes in the last 2 weeks?

	Yes	No	Further information:
Chronic fever, unexpected weight loss or gain, fatigue			
Ear, nose, or throat (hearing loss, running nose)			
Cardiovascular (chest pain, irregular heartbeat)			
Respiratory (shortness of breath, wheezing)			
Gastrointestinal (heartburn, abdominal pain, diarrhea, constipation)			
Urinary (painful urination, blood in urine, kidney stones)			
Skin (rashes, dryness, nail changes)			
Musculoskeletal (joint pain, aches)			
Neurological (numbness, headaches, stroke)			
Bleeding or clotting			
Psychiatric (anxiety, depression)			
Are you a smoker?			Quit when____________

______________________________ ______________
Patient's signature/representative Date

Dilating Eye Drops Consent Form

Please note dilating eye drops are used to dilate or enlarge the pupils of the eye in order to allow your doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from patient to patient and may make bright lights bothersome. Please note that it is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after your examination, it may be best to plan not to drive yourself or wait until your vision clears.

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.

Therefore, being duly informed, I hereby authorize Dr. ______________________________ or his/her assistant as may be designated by him/her to administer dilating eye drops. The eye drops, as understood, are necessary to properly diagnose my condition.

____ _________________________

Patient (or person authorized to sign for patient) Date

____ _________________________

Witness Date

Authorization for Release of Information

Patient Name:	Date of Birth:

Many of our patients allow immediate family members including spouse, parents, and children to call doctors offices and request medical, or billing information. Under the requirements of HIPAA, we are not allowed to disclose this or any other personal health information to anyone, regardless of their relationship with you. If you wish to have your medical or billing information released to a family member or caretaker, you must list their names within and sign this form. Signing this form will only authorize family members or caretakers listed below.

I authorize DLP Eye group to release my medical and/or billing information to the following individual(s):

1.	Relationship:
2.	Relationship:
3.	Relationship:

Furthermore, the doctors and staff at DLP Eye Group may leave messages regarding my healthcare or billing. AGREE____________ DISAGREE_________________ (SELECT ONE).

PATIENT INFORMATION:

I understand I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed or provided.

I understand that the information disclosed to any above recipient is no longer protected by Federal or State Law and may be subject to redisclosure by the above recipient(s).

Signature:	Date:
Internal Approval:	Date:

Patient Financial Responsibility Form

CANCELLATION AND NO SHOW POLICY:

Patients are expected to cancel *at least 24 hours in advance of their scheduled appointments*. NOTE: If you cancel an appointment on the same day of your appointment or fail to come to your appointment you may be charged a No Show Fee of $25.00. This notification is necessary in order to adequately allow us to reschedule you and/or fill your spot.

________________ (Please initial that you have read and fully understand this policy)

FINANCIAL POLICY:

I certify that the information I have reported is correct. I understand that it is the policy of this office that I'm responsible for obtaining pre-approval (precertification) from my health insurance carrier if that is needed. Furthermore, I understand that it is in my own best interest to ascertain what my related benefits are with my health insurance carrier and to know whether I have a co-pay, deductible, co-insurance or any other fees that I might have to pay DLP Eye Group.

I hereby assign and transfer to DLP Eye group my health insurance benefit payments. I also authorize the release of any medical information needed to determine my benefit payments.

I also fully understand that while DLP Eye Group will assist me in billing my insurance company, the ultimate responsibility is mine. Additionally, I agree that in the event of non-payment for services provided, to accept full and complete responsibility for the balance due, to pay collection agency costs, service costs, court costs and reasonable attorney fees should that action become necessary and as allowed by law.

_______________ (Please initial that you have read and fully understand this policy)

CONFIDENTIALITY:

As a health care specialist, it may be necessary to communicate in writing, phone, fax or electronic transmission to your primary care physician, other health care providers, health insurance companies, Medicare/Medicaid or health insurance clearinghouses, etc. Communication between your health care professionals is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information that you have agreed to be released as a participating member.

DLP Eye Group will make its best efforts to protect your privacy. This includes non-disclosure of your personal information for marketing and fund-raising purposes. I understand and agree that my personal health information may be transmitted electronically to consulting health care practitioners to facilitate my medical care.

I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated, and I will be able to see the new information. The Policy of this office is to strive to be in compliance with federal and state medical practice guidelines.

Patient's Name (Please Print): ____Date: _______________________

Signature of Patient____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

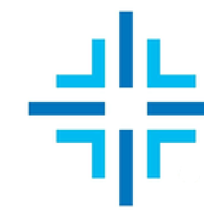
2446 W Whittier Bl, Montebello, CA 90640
139 S. Alvarado, Los Angeles, CA 90057
2715 E. Florence Ave, Huntington Park, CA 90255
1520 N Grand Ave, Santa Ana, CA 92701
7100 Van Nuys Bl, Ste 120 Van Nuys, CA 91405
10942 Ramona Blvd A, El Monte, CA 91731

I, ____, have reviewed/received.

or have been offered a copy of DLP Eye Group’s Notice of Privacy Practices.

______________________________________ ________________________

Signature of Patient/Guardian Date



Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

We are committed to treating and using your protected health information responsibly. Under federal and state law, your patient health information is protected and confidential. This Notice of Health Information Practices describes the personal health information we collect and how and when we use or disclose that information. It also describes your rights and our responsibilities as they relate to your protected health information.

Understanding your Health Record/Information

Each time you visit the facility, a record of your visit is made. Typically, this record contains your demographic information, medical history, procedure notes, test results, diagnoses, prescription copies, discharge instructions, and signed consents. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means for nursing to contact you for follow-up.
- Legal document describing the care you received, and consents you have given.
- Means by which a third-party payer (e.g., your insurance company) can verify who you are, and that services billed were actually provided.
- Source of information for public health officials charged with improving the health of this state and the nation (such as FDA).
- Means by which a pathology lab can process and bill for biopsy samples.
- Means by which we can assess and continually work to improve the care we render at our facility, and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Uses and Disclosures of your Health Information

As described above, your health information is used for a number of different and important purposes. In some circumstances, we may use or disclose your health information without seeking your permission.

The following are some examples of ways your information may be used or disclosed:

Treatment: We will use and disclose your health information for medical treatment purposes. For example, your doctors and nurses will update your medical record and use it to determine the best course of care. Additionally, your information may be disclosed to other health care providers involved in your treatment, or to the pharmacist who will be filling your prescriptions.
Payment: We will use and disclose your health information for payment purposes. For example, we will use your health information to prepare and submit bills and we may need to submit information to your insurance company to obtain authorization prior to providing certain types of treatment.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations. For example, we may use or disclose your health information to conduct quality assessment and improvement activities and for business management and other general administrative activities.
Special Uses: We may use your information to contact you with appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Other Uses or Disclosures: We may use or disclose your health information for the following purposes without your consent and, in some cases, we may be required to do so:

- Required by Law: We may be required to disclose your health information to certain legal authorities if it relates to suspected crimes, abuse, neglect, or similar injuries or events.
- Public Health Activities: We may be required to disclose your health information to public health officials for purposes of collecting vital statistics, information related to disease control, federal regulation of food and drug quality, safety, etc.
- Health Oversight: We may be required to disclose your health information to certain regulatory authorities for purposes of oversight of the health care system, government benefits programs, and regulatory compliance investigations or audits.
- Judicial and Administrative Proceedings: We may disclose your health information in response to a lawful subpoena, discovery request, or court order.
- Deaths: We may disclose information relating to deaths to coroners, medical examiners, funeral directors, or organ donation agencies.
- Serious Threat to Health or Safety: We may disclose your health information if necessary to prevent or lessen a serious threat to the health or safety of a person or the public.
- Military and Special Government Forces: If you are a member of the armed forces, we may
- disclose your information to appropriate military command authorities at their request.
- Additionally, we may disclose information to a correctional institution or law enforcement
- official as required for the care, health and safety of inmates and/or employees of the
- correctional institution.
- Research: In appropriate situations, we may disclose your health information for approved medical research.
- Workers' Compensation: We may disclose your health information in compliance with workers' compensation laws or similar programs.

State-Specific Requirements:

State-specific privacy laws may apply additional legal requirements. We will follow the state law requirements.

Other Uses and Disclosures

There are special regulations on certain health information including psychotherapy, substance abuse, mental health, genetic testing, reproductive health, and HIV/AIDS. As the surgery center does not generally treat such conditions, our records in these areas will be incidental to other health records which we may receive from other providers. Nevertheless, we will not disclose these types of records without specific written authorization. In any other situation not identified in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you decide to authorize the use or disclosure of your health information, you may later revoke such authorization, as provided by 45 CFR § 164.508(b)(5), to prevent the future use or disclosure of your health information in this way.

Your Health Information Rights

Although your health record is the physical property of the facility, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information for treatment, payment, health care operations, or other permitted purposes, as provided by 45 § CFR 164.522(a). Please note, however, that we are not required to agree to the requested restriction, except for a request to restrict disclosures to a health plan if the disclosure is for payment or health care operations purposes and pertains solely to a health care item or service for which you (or someone in your behalf) have paid your health care provider out of pocket in full.
- Receive confidential communications of your health information, as provided by 45 § CFR 164.522(b).
- Inspect and copy your health record as provided by 45 CFR § 164.524.
- Amend your health record as provided in 45 CFR § 164.526.
- Receive an accounting of disclosures of your health information as provided in 45 CFR § 164.528.
- Obtain a paper copy of this health notice of information practices upon request.

Our Responsibilities

The facility is required by law to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to
- information we collect and maintain about you.
- Abide by the terms of the notice of health information practices currently in effect.
- Notify you of any breach of your health information that we are required by law to report to you.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide a revised notice to you at your next visit should you request one.

For More Information or to Report a Problem

If you believe your privacy right has been violated, you can file a complaint as above with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint. The address for the OCR is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-527-7697 (TDD)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Covenant Physician Partners Compliance Help Line
Phone: 1-855-315-0528
covenantphysiciancompliance.com