Inland Valley Retina

Medical Associates, Inc.

Paul A. Blacharski, M.D. & Theodore K. Lin, M.D.

Dear Patient,

We want to take this opportunity to welcome you to Inland Valley Retina and to offer assistance in making your upcoming visit as comfortable and complete as possible.

Your appointment has been scheduled with:

❑ Paul A. Blacharski, M.D. ❑ Theodore K. Lin, M.D.

_____ @ _____ AM/PM, in _____

Appointment Date Time Location

We would appreciate it if you would ***completely*** fill out the enclosed **PATIENT INFORMATION, MEDICAL HISTORY QUESTIONNAIRE & NEW PATIENT CONSENT** forms. Bring the forms with you, along with your insurance cards and photo I.D. to your appointment. This will help expedite the check-in process and keep your wait to a minimum.

We, at Inland Valley Retina will make every effort to verify your insurance prior to your visit. There are instances when verification cannot be completed, and rescheduling your appointment may be necessary. We participate in the Medicare Program. Your co-payment is due prior to services rendered.

Please keep in mind you will be at your appointment for approximately 2-2 ½ hours during your retinal evaluation. Your pupils will be dilated with eye drops. For the safety of our patients we recommend you bring a family member or friend to drive you home as the effects of dilation can blur your vision.

Due to the nature of our specialty we sometimes see patients on emergency basis. We ask for your understanding if this delays your scheduled visit. Let us know if we need to reschedule your appointment. If you need any additional information, please feel free to give us a call at the telephone number listed below. The staff and Physicians would like to thank you in advance for choosing Inland Valley Retina for your retinal care. Our goal is to provide the best available care and address your questions and concerns.

The preservation and restoration of your vision is our primary concern.

Sincerely,

Inland Valley Retina

29798 Haun Road, Ste 200 Menifee, CA 92586 Phone: (951) 679-0400 FAX: (951) 672-6667
1810 Fullerton Avenue, Ste 206 Corona, CA 92881 Phone: (951) 738-8383 FAX: (951) 672-6667
41900 Winchester Road, Ste 201, Temecula, CA 92590 Phone: (951) 679-0400 FAX: (951) 672-6667

Inland Valley Retina
Office Directions

Menifee:

Take **I-215 freeway** South from riverside, North from Temecula, to **Newport** exit, Proceed west to the first light, **Haun Rd.** Turn right and take the third right into the parking. You will see a three-story building. We are on the second floor across from the elevator, suite 200.

From **Corona** or **Lake Elsinore** take **I-15 south**, exit **Railroad Canyon Rd** and turn left. Proceed on Railroad Canyon Road through Canyon Lake Village. Railroad Canyon turns into **Newport Rd.** Proceed approximately 5 miles to **Haun Rd.** Turn left (last light before I-215). And turn right into third parking lot of **Hope Medical Arts Plaza**.

Hope Medical Arts Plaza
29798 Haun Road, Suite 200, Menifee, CA 92586
Phone: 951.679.0400 FAX: 951.672.6667

Temecula:

Take **I-15 freeway South** to **Winchester** Exit, Turn right and proceed west for approximately ½ mile to the third *SIGNAL LIGHT* at **Diaz Road**. Turn left and enter the first parking lot on the right **(Park Place)**.

Park Place
41900 Winchester Rd, Suite 201, Temecula, CA 92590
Phone: 951.679.0400 FAX: 951.672.6667

Corona:

From the **91 freeway East**, take **I-15 South** toward San Diego, exit on **Magnolia Ave** turn right and proceed to **Fullerton Ave**.. Turn left and enter the second driveway on your right. We are in the **Corona Medical Plaza**.

From the **91 freeway West**, take **I-15 South** toward San Diego, exit on **Magnolia Ave** turn right and proceed to **Fullerton Ave**.. Turn left and enter the second driveway on your right. We are in the **Corona Medical Plaza**.

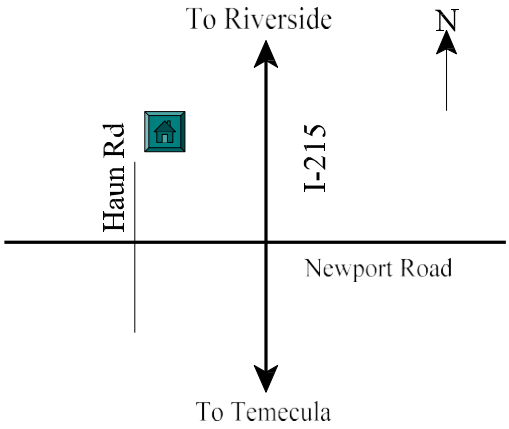
From the **I-15 freeway South**, take **I-15 South** toward San Diego, exit on **Magnolia Ave** turn right and proceed to **Fullerton Ave**.. Turn left and enter the second driveway on your right. We are in the **Corona Medical Plaza**.

From the **I-15 freeway North**, exit **Ontario Ave**. Turn left and proceed to **Fullerton Ave** turn right and proceed to **1810 Fullerton Ave** on your left. If you have reached Magnolia you have gone too far.

Corona Medical Plaza
1810 Fullerton Ave, Suite 206, Corona, CA 92881
Phone: 951.738.8383 FAX: 738.8788

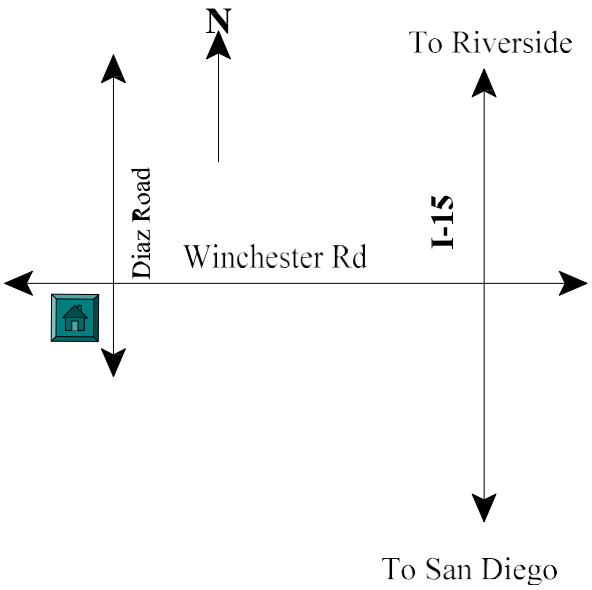
Menifee Location

Hope Medical Arts Plaza
29798 Haun Rd, Suite 200
Menifee, CA 92586



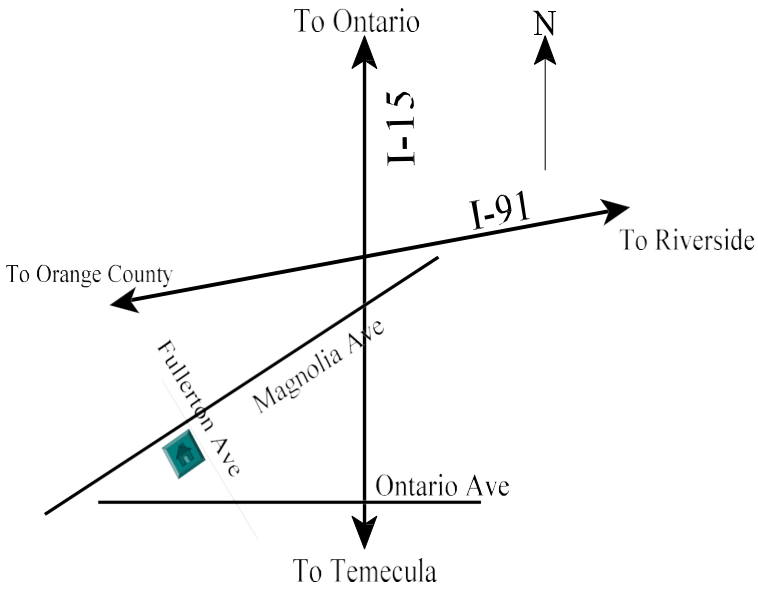
Temecula Location

Park Place
41900 Winchester Rd, Suite 201
Temecula, CA 92590



Corona Location

Corona Medical Plaza
1810 Fullerton Ave, Suite 206
Corona, CA 92881



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MRN _____

Patient Information

Patient _____ Date of Birth ____/____/____
Last First Middle

❒ Home Address or ❒ Nursing Facility

Address _____

City _____ State _____ Zip Code _____

Home Telephone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

E-Mail _____

Preferred method of contact: ❒Home Phone ❒Cell Phone ❒Work Phone

Appointment Reminders: ❒Email ❒Text ❒Voice ❒ Opt Out

Marital Status ____ Gender _____ Drivers Lic. # _____Social Security # _____-____-_____

Employer _____ Occupation _____

Employer Address _____ Telephone (____) _____

In Case of Emergency

Name_____Relationship_____

Address_____ Telephone (____) _____

Accident Industrial/Work related? Yes ❒ No ❒ Non-Work related: Auto? Yes ❒ No ❒
Did you come through the Emergency Room? Yes ❒ No ❒ Other? Yes ❒ No ❒

Date of Injury_____ Has employer been notified?_____ Has carrier been notified?_____

Industrial Insurance_____ Policy #_____

Address_____ Telephone_____

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Primary Care Doctors

Family Physician: Name_____ Telephone (____)_____

Address_____

Optometrist/ Ophthalmologist: Name_____ Telephone (____)_____

Address_____

Medical Insurance Information

(1) Primary:

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____SS#:_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

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(2) Secondary: ❑ MEDIGAP ❑ Employer Retiree ❑ Employer Secondary

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____SS#:_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

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(3) Tertiary: ❑ MEDIGAP ❑ Employer Retiree ❑ Employer Secondary

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____SS#:_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effects of the medicine have worn off or that I feel safe in driving. The effects of the drops may last an hour or longer.

Signature_____ Date _____

1810 Fullerton Avenue, Ste 206
Corona, CA 92881

29798 Haun Road, Ste 200
Menifee, CA 92586

41900 Winchester Rd, Ste 201
Temecula, CA 92590

Phone: (951) 679-0400 **Fax: (951) 672-6667**

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FINANCIAL RESPONSIBILITY AGREEMENT

I understand I am financially responsible to **Inland Valley Retina** for any charges incurred and not paid for by my insurance company/companies. I understand that it is my responsibility to pay **Inland Valley Retina** for any deductible, co-payments, and balances not paid for by my insurance company/companies. I understand that co-payments and deductibles are due at time of visit or procedure. I understand that if I am a member of a Health Maintenance Organization (HMO), I am responsible for obtaining prior authorization from my Primary Care Physician for all visits and procedures performed in our offices. I understand that if prior authorization is not obtained, I may be financially responsible for the charges incurred on that particular date of treatment.

A $25 charge will be added to your account for broken appointments unless a 24 hr notice is given

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoke by me.
4. I agree that a photocopy of this form may be used in lieu of the original.

Signed (patient or representative)_____ Date _____

Print Name _____

Signed (insured if other that patient)_____ Date _____

MRN _____

Birthdate _____

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In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your race, ethnicity and preferred language. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name: _____ Date: _____

Race:
___America Indian or Alaska Native
___Asian
___African America
___Caucasian
___Hispanic
___Native Hawaiian or Other Pacific Islander
___Other_____

Ethnicity:
___Hispanic
___Non-Hispanic

Primary Language:
___Arabic
___Chinese
___English
___French
___Korean
___Spanish
___Other_____

Prefer Not To Answer: _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, and/or Healthcare Operations

I, _____, understand that as part of my health care, Inland Valley Retina originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Inland Valley Retina is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Inland Valley Retina reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Inland Valley Retina change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent.

_____ _____

Patient Signature / Legal Guardian Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/DESIGNATED INDIVIDUALS

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals you designate, we must obtain your authorization prior to doing so. In the event of a critical episode of if you are unable to give your authorization due to the severity of your medical condition; the law stipulates that these rules may be waived.

_____***NO***, I do not authorize Inland Valley Retina to verbally release any or all information concerning my medical care on any personal answering machine/voice mail (this includes appointment reminders).

_____***YES***, I authorize Inland Valley Retina to verbally release any or all information concerning my medical care on my personal answering machine/voice mail, and/or any of the phone numbers I provided on my Registration form.

_____***NO***, I do not authorize Inland Valley Retina to release any or all medical information concerning my medical care to anyone other than myself.

_____***YES***, I authorize Inland Valley Retina to verbally release any or all information concerning my medical care to only those ***individuals I have listed below*.**

_____ _____

Name Relationship to patient

_____ _____

Name Relationship to patient

X_____ _____

Patient Signature / Legal Guardian Date

_____ _____

Witness Signature Date

Inland Valley Retina

Medical History Questionnaire / *Cuestionario Médico*

Name/ *Nombre*_____ Date/ *Fecha*: _____

Date of Birth: _____ Date of **Last Eye Exam:**_____
Fecha de Nacimiento *Fecha de último examen visual*

Chief Visual Complaint: What is your main visual complaint and how long have you had it?
¿Cuál es su principal reclamo visual y por cuánto tiempo lo ha tenido?

_____

List **Trauma** affecting head or eyes:_____
Lista de los traumas a la cabeza o los ojos

Do you currently have any problems in the following areas?
¿Tiene actualmente algún problema en las siguientes áreas?

Eyes ***Ojos***	Yes *Si*	No	Explanation *Explicación*	**Family History pertaining to eyes** ***Antecedentes familiares relativos a los ojos***	Yes *Si*	No
Loss of vision *Pérdida de vision*				Glaucoma *Glaucoma*		
Blurred vision *Visión borrosa*				Macular Degeneration *Degeneración Macular*		
Fluctuating vision *Fluctuación de la visión*				Myopia *Myopia*		
Distorted vision *Visión distorsionada*				Unexplained poor vision *Mala visión inexplicable*		
Loss of side (peripheral) vision *Perdida de la visión de un lado*				Cataract *Cataratas*		
Double vision *Visión doble*				Night blindness *Ceguera nocturna*		
Eye pain *Dolor de ojo*						
Excess tearing *Ojos llorosos/lagrimeo*						
Light sensitivity *Sensibilidad a la luz*						
Redness *Enrojecimiento*						
Itching *Comezón*						
Discharge *Secreción ocular*						
Poor night vision *Mala visión nocturna*						
Curtain effect *Efecto de cortina*						
Flashing lights *Destellos de luz*						
Floaters *Flotadores*						
Other eye conditions *Otros trastornos oculares*						

Past Medical History ***Historial Médico***	Yes *Si*	No	How long?/Comments *Desde Cuando? Comentarios*	**Personal Habits** ***Hábitos personales***	Yes *Si*	No
Hypertension *Hipertensión*				Alcohol *Alcohol*		
Anemia or Blood Disorder *Anemia o desorden de la sangre*				Smoking *Fumar*		
Heart Disease *Enfermedades del Corazón*				Recreational Drugs *Drogas recreativas*		
Diabetes *Diabetes*				Occupational Hazards *Riesgos Laborales*		
Cancer *Cáncer*						
Cholesterol *Colesterol*						
Drug abuse history *Historia de abuso de drogas*						
Tuberculosis *Tuberculosis*						
Stroke *Infarto*						
Thyroid Disease *Enfermedad de la tiroides*						
Inherited Diseases *Enfermedades hereditarias*						

Do You have **Allergies** to medications? [ ] Yes [ ] No
¿Es alérgico(a) a algún medicamento?

If Yes, List the medications: _____
Si es alérgico(a), a cual medicina

List Medications presently taking: _____
¿Cuáles medicamentos toma?

List Major Eye Surgeries: _____
Lista de cirugías de ojos

Pharmacy Name:_____

Address/Street Name:_____

City:_____**Telephone:**_____