BARRANCA OPTOMETRY
4482 Barranca Parkway, Suite 190
Irvine, CA 92604

Dr. Raymond Huang, O.D.
Dr. Crystal Muraoka,O.D.

Welcome to our office!

Date _____

Name: _____ Spouse: _____
Last First MI

Address: _____
City State Zip

Home #: _____ Work/Cell #: _____ Email: _____

Birthday ____/____/_____ Age _____ Sex _____ Occupation _____

Vision Insurance ID/SSN _____-____-_____ Employer _____

If the patient is a dependent, name of parent/guardian responsible for the account.

Name: _____Date of Birth_____Relationship to patient: _____

Date of last eye exam: _____ By whom? _____

Are you having problems seeing:
In the distance? □Y □N with glasses? □
Up close/reading □Y □N contacts? □
At computers? □Y □N or both? □

If you wear contacts, what brand/type do you use? RGP □ Soft □ Brand: _____

Have you or your family members ever been diagnosed with any of the following conditions?

	Yourself	Family	If a family member, what is the relationship?
High blood pressure	□Y □N	□Y □N	
Diabetes	□Y □N	□Y □N	
Thyroid disorder	□Y □N	□Y □N	
Heart disease	□Y □N	□Y □N	
High cholesterol	□Y □N	□Y □N	
Cancer (type_____)	□Y □N	□Y □N	
Glaucoma	□Y □N	□Y □N	
Macular degeneration (ARMD)	□Y □N	□Y □N	
Lazy eye (Amblyopia)	□Y □N	□Y □N	
Eye turn (Strabismus)	□Y □N	□Y □N	

Date of last physical exam: _____ By whom?_____
Do you currently take any medications? □Y □N If yes, please list _____
Are you allergic to any medication? □Y □N If yes, which ones? _____
Any other known allergies? □Y □N If yes, to what? _____
Have you had eye surgery? □Y □N If yes, what kind and when? _____

I authorize the release of medical information necessary to provide the most beneficial/complete visual examination. I understand that I am financially responsible for all charges whether or not paid for by insurance. Payment is due at the time services are rendered.

_____
Signature of patient or responsible party

CONTACT LENS PATIENT: Your success with contact lenses depends upon follow-up care. We would like to see you after one week of wearing your new diagnostic lenses. It is your responsibility to schedule and keep this appointment. Furthermore, contact lenses are medical devices. It can cause serious eye problems without proper care and routine follow-up. Therefore, **OUR OFFICE CANNOT RELEASE YOUR CONTACT LENS PRESCRIPTION WITHOUT FINALIZING YOUR CONTACT LENS EXAM WHICH INCLUDES THE FOLLOW- UP VISIT AT THE DOCTOR'S DISCRETION.**

Please sign below to indicate your understanding of our office policy.

_____
Signature of patient or responsible party

Updated 11/1/13

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION **DATE**_____

I consent **BARRANCA OPTOMETRY** to use and disclose the health and medical information of _____for the purposes of Treatment, Payment and Health Care Operations.*
(Name of Patient)

*__Treatment__ (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

You may review **Barranca Optometry** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

*I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that **Barranca Optometry** has already used or disclosed the information in reliance on this Consent.*

_____
Signature of Patient

_____
Signature of Person Authorized by Law

_____
Date

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP, Eyemed, Spectera, Davis)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____

Patient signature (parent if child) Date

Please provide your insurance cards to our staff member.

Updated 11/1/13

NOTICE: PATIENT PRIVACY

Dear Patient:

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicated the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Raymond Huang of our office at Barranca Optometry.