Name:
Chart:
Date:

CARSON, MCBEATH & BOSWELL, INC.
SOUTH COAST RETINA CENTER

STANLEY CARSON, M.D.
JOHN B. MCBEATH, M.D.
FOX M. BOSWELL, M.D.
RANDALL L. NGUYEN, M.D.
MICHAEL L. ROH, M.D.

DEAR PATIENT

AN APPOINTMENT HAS BEEN SCHEDULED FOR YOU AT OUR OFFICE ON:

____AT___________________________

YOU MUST CALL THE OFFICE TO CONFIRM THE APPOINTMENT DATE AND TIME AND OBTAIN INSTRUCTIONS

BECAUSE YOUR EYES WILL BE DILATED, YOU WILL NEED A DRIVER. PLAN ON BEING IN OUR OFFICE FOR ONE AND A HALF HOURS TO TWO HOURS. YOU DO NOT NEED TO ARRIVE PRIOR TO YOUR APPOINTMENT TIME.

PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM TO THE OFFICE THE DAY OF YOUR APPOINTMENT. YOU WILL ALSO NEED TO BRING YOUR INSURANCE CARDS A LIST OF ALL MEDICATIONS YOU ARE USING, AND YOUR INHALER, IF YOU USE ONE. PLEASE BRING YOUR GLASSES AND A CONTACT LENS CASE IF YOU WEAR CONTACT LENSES. CONTACT LENSES CANNOT BE WORN FOR SIX HOURS AFTER YOUR EXAMINATION.

PLEASE BE PREPARED TO PAY YOUR INSURANCE CO-PAY AT THE TIME OF YOUR EXAMINATION.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT, PLEASE DO NOT HESITATE TO ASK FOR THAT INFORMATION AT THE TIME YOU CALL TO CONFIRM YOUR APPOINTMENT.

THANK YOU

FC 6

4300 LONG BEACH BLVD. #300
LONG BEACH, CA 90807-2008
PH 562.984.7024
FAX 562.428.7394

2601 AIRPORT DRIVE, SUITE 210
TORRANCE, CA 90505-6141
PH 310.534.2209
FAX 562.428.7394

7677 CENTER AVE. SUITE 302
HUNTINGTON BEACH, CA 92647
PH 714.657.7809
FAX 562.428.7394

Name:
Chart:
Date:

CARSON, MCBEATH & BOSWELL, INC.
SOUTH COAST RETINA CENTER

NEW PATIENT INFORMATION RECORD DATE ____________

PATIENT'S LAST NAME FIRST NAME	DATE OF BIRTH	SEX	AGE	EMAIL ADDRESS

ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE

☐ SEND TO BILLING ADDRESS BELOW BILLING ADDRESS	CELL PHONE

PATIENTS CURRENT EMPLOYER / OR LAST EMPLOYER, IF RETIRED	ADDRESS	WORK PHONE

OCCUPATION	SOCIAL SECURITY NO.	DRIVER'S LICENSE NO.

NAME OF SPOUSE	SPOUSE'S EMPLOYER	ADDRESS

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	NAME OF NEAREST RELATIVE NOT LIVING WITH YOU	PHONE

DEMOGRAPHICS			SMOKING STATUS
Race Choices	**Ethnicity Choices**	**Language Choices**	☐ Current every day smoker
☐ American Indian	☐ Hispanic Origin	☐ Chinese	☐ Current occassional smoker
☐ Asian	☐ Non-Hispanic	☐ English	☐ Smoker, current status unknown
☐ Black	☐ Type-Unknown	☐ French	☐ Never smoker
☐ Native Hawaiian		☐ Hebrew	☐ Former smoker
☐ Type-Unknown		☐ Hindi	☐ Unknown if ever smoked
☐ White		☐ Japanese	
☐ Other		☐ Korean	
		☐ Spanish	
		☐ Vietnamese	
		☐ Other	

REFERRED TO THIS OFFICE BY: ____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE CO.		ADDRESS	NAME OF POLICY HOLDER
CERTIFICATE NO.	GROUP NO.	INSURED'S SOCIAL SECURITY NUMBER	INSURED DOB
SECONDARY INSURANCE CO.		ADDRESS	NAME OF POLICY HOLDER
CERTIFICATE NO.	GROUP NO.	INSURED'S SOCIAL SECURITY NUMBER	INSURED DOB

Name:
Chart:
Date:

INFORMED CONSENT: I consent to the use or disclosure of my health information for the purpose of treatment, payment, and health care operations, including any insurance company, adjustor, or attorney involved in this case. ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay by check made out and mailed to Carson, McBeath & Boswell, Inc. and its affiliated Physicians.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this consent document shall be considered as effective and valid as the original.

Date: ______________________ Signature of Patient: ____

Witness: ____

Signature of Policyholder: ____ FC 5

Name:

Chart: DOB: Gender:

Date: Referring Dr.:

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JULIE L. GASPERINI, M.D.

What is the problem with your vision? Which eye? When did problem start?

EYE HISTORY: HAVE YOU EVER HAD?:

	yes	no	When? / Which eye?
Cataract surgery			
Any laser or refractive surgery (LASIK)			
Retinal detachment repair			
Glaucoma surgery or being treated for glaucoma			

FAMILY HISTORY OF EYE / SYSTEMIC DISEASES: (CHECK IF YES)

___ glaucoma	**___blindness**	**___cataract**	**__retinal detachment**
___macular dystrophy	**___retinal degeneration**	**___macular degeneration**	**___stroke**
___hypertension	**___diabetes**	**___cancer**	**other:______________**

GENERAL HEALTH HISTORY:

	YES	NO	Clarify or **circle**
CANCER: what kind? When? Treated or active?			
HEART ATTACK/STROKE: what? when?			
ANY HEART SURGERY OR PACEMAKER: when?			
-taking BLOOD THINNERS (PLAVIX, COUMADIN, ASA, ETC)			
HIGH BLOOD PRESSURE: how long?			**Controlled or not well controlled**
DIABETES: how long? **LAST HGA1C is:**			**INSULIN PILLS NONE** (circle)
ON DIALYSIS:			**M-W-F OR T-TH-SAT**
DO YOU __ SMOKE __ USE ALCOHOL __ DRUGS			
OTHER:			

LIST ALL MEDICATIONS (I.E. HERBAL, BLOOD THINNERS, ASPIRIN, VITAMINS):

Name:

Chart: DOB: Gender:

Date: Referring Dr.:

ANY ALLERGIES TO MEDICATIONS? ___NO; or if YES - include reactions:

MED:

LIST ALL SURGERIES:

REVIEW OF SYSTEMS:

Do you CURRENTLY have any problems in the following areas?		
… if yes, circle or provide details…..	**YES**	**NO**
CONSTITUTIONAL: recent fevers, chills, unplanned weight loss, etc		
EARS/ NOSE/ MOUTH/ THROAT: hearing loss, sinus problems, mouth ulcers, dry mouth, etc.		
CARDIOVASCULAR: chest pain, racing pulse, high blood pressure, difficulty breathing laying flat or walking up stairs, etc		
RESPIRATORY: wheezing, shortness of breath, coughing up blood, etc		
GASTROINTESTINAL: nausea, vomiting, abdominal pain, diarrhea, constipation, black or bloody stool, etc..		
GENITOURINARY: frequent or burning urination, blood in urine, etc		
MUSCULOSKELETAL: joint pain/ arthritis, back pain, pain with chewing, etc		
SKIN: rash, itching, unusual red or black or white skin patches, hair loss, skin tumors/growths, etc		
NEUROLOGICAL: numbness, seizures, headaches, fainting spells, tremors, temple ache, weakness, etc		
PSYCHIATRIC: depression, anxiety, hallucinations, difficulty sleeping, disorientation, etc		
ENDOCRINE: diabetes (frequent nighttime urination), thyroid problems (fatigue, hair loss, hot/cold intolerance)		
BLOOD/LYMPH: Painful or swollen lumps, easy bruising, prolonged bleeding, low blood count, leukemia/lymphoma, etc		
ALLERGIC/IMMUNOLOGIC: recurrent infections, HIV, drug sensitivity, hay fever, hives, itching, redness, etc…		

-Primary care doctor is/ (include phone #/city): ______________________________

FORM WAS FILLED OUT BY: x ______________________________ **PATIENT/FAMILY/TECH**

REVIEWED BY:______________________ **MD or see EXAM form** **DATE:** ________________

☐ **ARBITRATION** ☐ **DECLINED**

Name:
Chart:
Date:

WAIVER FORM

Eligibility of coverage for treatment has not been verified. However, I wish to receive medical treatment at this time.

I understand that if it is determined that I am not eligible for coverage I will be responsible for all charges that may occur for services provided.

I understand you will submit my claims to my insurance company however if you do not receive payment after two attempts, I will be responsible for the balance. I understand that you will supply the necessary paperwork for me to submit my claim to my insurance company so I will be reimbursed for the services rendered. (This does not apply to Medicare patients)

Some insurance companies will only pay for services that it determines to be "reasonable and necessary". Your insurance company may determine that a particular service, although it would be otherwise covered, is not "reasonable and necessary" and your insurance will deny payment for that service. Some insurance companies have notified our office certain procedures are non covered or investigational according to their policies and therefore deny payment.

I, the undersigned, acknowledge that my physician has informed me that the processing of my claim by my insurance carrier is not a guarantee of payment; therefore if my claim is denied by my insurance, I agree to be personally and fully responsible for payment to Carson, McBeath & Boswell, Inc., South Coast Retina Center. This waiver does not have an expiration date.

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received a copy of the Notice of Privacy Practices for Carson, McBeath & Boswell, Inc. South Coast Retina Center, as required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand that this organization reserves the right to modify the Privacy Practices outlined in this notice

PATIENT OR RESPONSIBLE PARTY | **CHART #:**

WITNESS OR OFFICE PERSONNEL | **DATE**

Name:
Chart:
Date:

NOTICE OF PRIVACY 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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Name:
Chart:
Date:

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Carson, McBeath, & Boswell, Inc.
South Coast Retina Center
4300 Long Beach Boulevard, Suite 300
Long Beach, California 90807
562-984-7024

For more information about HIPAA

Or to file a complaint:
The U.S. Department of Health &
Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C, 20201
(202) 619-0257
Toll Free: 1-877-696-6775

____
PATIENT OR RESPONSIBLE PARTY

Name:
Chart:
Date:

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

1. I authorize Dr.____________________________________to disclose complete information to_________________________________concerning his medical findings and treatment of the undersigned OR limited information from______________________200__ until the date of conclusion of such treatment.

2. Further, I authorize him to testify, without limitation, as to all of his medical findings and the treatment administered to the undersigned, in any legal action, suit or proceedings to which I am, or may become a party; and I waive on behalf of myself and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of confidential medical information.

Signed: ____

Printed name:

Date of Birth:

Date:

Witness: ____

FC 2

Name:
Chart:
Date:

eRx Authorization

I agree that Carson, McBeath & Boswell, Inc. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

PATIENT OR RESPONSIBLE PARTY	**CHART #:**
WITNESS OR OFFICE PERSONNEL	**DATE**