# Patient Information

Patient's Full Name: ____________________________________________ Date: ____ /____ /____

Date of Birth: ____ /____ /____ Gender: ☐ Male ☐ Female Social Security #: ________________________

Home Address: ____________________________________________________________________

City: ____________________________________ State: _______ Zip Code: ___________________________

Home Phone#: ___________________________ Secondary Phone#: ______________________________

E-mail: __________________________________________________________________________

**Preferred Method of Contact**: ☐Email ☐ Phone Call ☐ Text Message*

*For Text Messages, Please Provide Cell Phone Carrier: ______________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Language: ☐English ☐ Spanish ☐ Other: ______________________________________

**Insurance Information**

Employer: ________________________________________ Work Phone#: __________________________

Please fill in information below.

**Medical Insurance**

Insurance Carrier: _______________________________

Member ID #:___________________________________

Policy Holder Name:______________________________

Policy Holder Date of Birth:________________________

Relationship to Policy Holder:

☐ Self ☐ Spouse ☐Dependent

**Vision Insurance**

Insurance Carrier: _______________________________

Member ID #:___________________________________

Policy Holder Name:______________________________

Policy Holder Date of Birth:________________________

Relationship to Policy Holder:

☐ Self ☐ Spouse ☐Dependent

**Secondary Insurance**

Insurance Carrier: _______________________________

Member ID #:___________________________________

Policy Holder Name:______________________________

Policy Holder Date of Birth :________________________

Relationship to Policy Holder:

☐ Self ☐ Spouse ☐Dependent

**Emergency Contact**

Name: __________________________________________

Relationship To Patient:___________________________

Address: ________________________________________

City, State, ZIP :_________________________________

Phone #: ________________________________________

Secondary Phone #: _______________________________

If Patient Is A Minor, Legal Guardian's Printed Name:______________________________________________

Patient Signature (or legal guardian if patient is a minor): ______________________________ Date: _____ /_____ / _____

# Medical History Interview

Patient Name: ______________________________ Age: __________
Name of Primary Medical Doctor: ______________________ Last Medical Exam: __________
Name of Referring Doctor: ______________________ Last Eye Exam: __________
Referring Doctor's Office City: ______________ Referring Doctor's Phone #: __________

**What is your reason for visiting us today?** (Please mark all that apply)

| | | | |
|---|---|---|---|
| ☐ clinical research | ☐ eye pain/discomfort | ☐ burning eyes | ☐ broken glasses |
| ☐ blurred vision | ☐ light sensitivity | ☐ watery eyes | ☐ contact lenses |
| ☐ double vision | ☐ flashes/spots | ☐ discharge | ☐ laser vision correction |
| ☐ distorted vision | ☐ blind spot | ☐ cataracts | ☐ Botox®/Restylane® |
| ☐ computer strain | ☐ red eyes | ☐ glaucoma | ☐ facial rejuvenation therapy |
| ☐ headaches | ☐ itchy eyes | ☐ lazy eye | ☐ other: __________ |

Have you had an eye injury? ☐ No ☐ Yes If yes, please explain: ______________________
Have you had eye surgery? ☐ No ☐ Yes If yes, please explain: ______________________
Have you ever been hospitalized? ☐ No ☐ Yes If yes, please explain: ______________________

**What is your Medical History?** Do you have, or have you ever been treated for:

| | | | |
|---|---|---|---|
| ☐ diabetes (high sugar) | ☐ arthritis/joint paint | ☐ headaches | ☐ skin condition |
| ☐ high blood pressure | ☐ kidney/urinary | ☐ muscle disease | ☐ sinus/allergy |
| ☐ breathing problems | ☐ thyroid disease | ☐ STD/HIV | ☐ blood illness |
| ☐ stomach problems | ☐ psychiatric illness | ☐ cancer | ☐ stroke |
| ☐ hearing problems | ☐ other: ______________________ | | |

Do you take any medications? ☐ No ☐ Yes If yes, please list:
______________________________________________
______________________________________________

Do you have any allergies? ☐ No ☐ Yes If yes, please list:
______________________________________________
______________________________________________

Are you now pregnant or breast-feeding? ☐ No ☐ Yes
Do you smoke? ☐ No ☐ Yes If yes, how much? ______________
Do you drink alcohol? ☐ No ☐ Yes If yes, how much? ______________
Do you have a history of recreational drug use? ☐ No ☐ Yes If yes, please list:
______________________________________________
______________________________________________

**List the people in <u>your family</u> who have the following medical problems**:

| | | |
|---|---|---|
| __________diabetes | __________arthritis | __________macular degeneration |
| __________high blood pressure | __________blindness | __________crossed eyes |
| __________heart disease | __________glaucoma | __________other: |

**Please indicate any of the following topics which you would like to learn more about today**:

| | | |
|---|---|---|
| ☐ laser vision correction | ☐ Restylane® | ☐ chemical peels |
| ☐ cataract surgery | ☐ eyelid tucks | ☐ anti-aging creams |
| ☐ Botox® | ☐ facial rejuvenation | ☐ Clinical Research |

# HIPAA Privacy Regulations

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health & Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the OC Surgical will not reveal to any person, personal information about you or about a family member (i.e. name, address, Social Security number, as well as other health information) without permission. Your information will never be sold or listed for the purpose of advertisement, solicitation or fundraising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verification, billing, paper and wire (includes fax transmission), insurance company follow up or interaction with billing services relating to patient care
- Pursue collection of unpaid bills
- Hospital workers, nurses, aides, and medical records department
- Emergency officials, paramedic, fire personnel, emergency room physicians, nurses or technicians
- Personal religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

*I, ________________________________ (patient's name) hereby authorize the release*

*of this necessary information to ___________________________________.*

Patient Signature (or Patient's guardian) Date

# NOTICE OF PRIVACY PRACTICES

## OC SURGICAL

2010 E First St. Suite 160
Santa Ana, CA 92705
(714) 647.1200

**Effective Date: January 1, 2015**

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.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

### A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates,

California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities, which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]***

4. **[Optional: Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notifications and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. **[Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.] [*Add the following***

***three activities, or any of the three, only if the organization engages or intends to engage in these activities*.]**

22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

**B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**C. Your Health Information Rights**

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee, which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can

disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

**5. Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

**6.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

**D. Changes to this Notice of Privacy Practices**

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **[*For practices with websites add*: We will also post the current notice on our website.]**

**E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

**Michael A. Sheety, M.D., F.A.C.S**

2010 East First St. Suite 160 Santa Ana, CA 92705

Phone: 714.647.1200 . Fax: 714.361.6724

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

________________________________________.

Patient's Name: ____________________________________ Date: ______________________

Patient/Guadian Signature: ___________________________ Date: ______________________

If not signed by patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

## AGREEMENT OF PAYMENT

I, ________________________________________ (patient/guarantor's name), agree that I am fully responsible for fees, which may or may not be covered by insurance, regarding all the services rendered at OC Surgical for ___________________________________________ (patient's full name).

**Please read the following agreement of payment carefully.** There are different kinds of insurance coverage for health services. **ULTIMATELY, IT IS YOUR RESPONSIBILITY** to find out the terms of your insurance coverage (What is your deductible, co-insurance, and/or co-payment). Any questions regarding your insurance coverage should be addressed with your insurance carrier prior to the scheduled appointment. However, we will be glad to assist you and try to answer your questions or concerns.

**You are responsible for knowing your insurance policy.** For example, you will be responsible for any charges if any of the following apply: (i) your health plan/medical group requires prior authorization or referral by a primary care physician before receiving services at OC SURGICAL, and you have not obtained such an authorization or referral; (ii) you received services in excess of such authorization or referral; (iii) your health plan determines that the services you received at OC SURGICAL are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at OC SURGICAL. **If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.**

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, and paying any co-pays or other patient's responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered a self-pay patient. As a self-pay patient, our fee is required to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, OC SURGICAL may reschedule your visit. If you do not provide your updated information within 2 weeks of changing your insurance or by the upcoming appointment you will assume all liability caused by lack of coverage, late filing or non-participation.

**Deductibles and Co-insurance Dues.** This section will apply if you are using insurance and you have deductible and/or co-insurance. Coinsurance means that you share a percent of the costs of a covered health care service. The amount is calculated as of the allowed amount for the service. For example, if your health insurance or plan's allowed amount for an office visit is $100 and you have a 20% coinsurance, you will pay the physician $20 and your health plan will pay the physician the rest of the allowed amount ($80). A **deductible** is a predefined dollar amount that must be paid by you toward the cost of covered services before the plan begins to pay benefits. When you have a deductible, you are responsible for 100% of the Amount Allowed for a service until you've paid an amount equal to your deductible. After that, your health plan pays the majority of the costs -- perhaps 80% -- but you are still responsible for the remainder (in the form of coinsurance or copayment).

If your insurance carrier does not remit timely payment on your claim, you will be responsible for Payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit it to OC SURGICAL until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize OC SURGICAL to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, and any remaining balance will be returned to the payer.

I understand that OC SURGICAL will be billing my insurance company for an office visit and/or supplemental testing services rendered. Co-insurance and deductible dues are based upon the charge determination of my insurance carrier. I further understand that all charges that are not covered by my insurance company are my responsibility. Specifically, I will be responsible for any co-insurance and deductibles. All deductible and co-insurance balance payments are due immediately upon receipt of billings. I will be billed to my billing address for the outstanding monies. I can pay with cash, check or credit card. OC SURGICAL will not extend credit beyond 15 days from the date of the invoice. I understand and authorize that if I have not paid the balance in fifteen days (15) from the due date in the invoice sent to me, I will be charged to the credit or debit card placed on file as a payment guarantee for all unpaid services rendered. I also understand that if OC SURGICAL is unable to collect payment, my account will be in default and may be referred to a collection agency.

--------------------
Initial (Patient, Parent/ Guardian or Party Responsible)

**Co-payments.** This section will apply if you are using insurance and you have co-payments. A copayment (or copay) is a fixed-dollar amount that you pay each time you see the physician. All insurance co-payments are due at the time of service. No patient is authorized to run a balance by accumulating unpaid copayments, unless it is formally approved by the administration. I understand that I am responsible to satisfy my copayment at the time of service.

--------------------
Initial (Patient, Parent/ Guardian or Party Responsible)

**Missed Appointments and Late Cancellations.** Missed appointments and late cancellations prevent other patients to use our service and constitute a financial burden to the organization. OC SURGICAL requires that you notify the office of any cancellation no later than one business day before your appointment. I understand that OC SURGICAL does not charge for a missed or cancelled appointment but it is my responsibility to call at least 24 hours prior to my appointment to make the appropriate changes.

--------------------
Initial (Patient, Parent/ Guardian or Party Responsible)

**Full Payment (No insurance).** If you are not using insurance, OC SURGICAL requires that charges rendered by our physicians be paid for at the time of service unless other formal arrangements have been made with our administration. OC SURGICAL fees may vary based on what type of appointment and or services rendered.

--------------------
Initial (Patient, Parent/ Guardian or Party Responsible)

**Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00, in addition to any costs assessed or charged by any depository institution.

**Additional Charges.** Patients may incur and are responsible for the payment of additional charges at the discretion of OC SURGICAL including but not limited to: (i) charges for extensive phone consultations and/or after-hours phone calls requiring treatment (ii) charges for copying and distribution of patient medical records; (iii) charges for extensive forms preparation or completion requested by the patient; or (iv) any costs associated with collection of patient balances, all as allowed by law.

**Non-Payment on Account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that OC SURGICAL has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Withdrawal of Care.

**Financially Responsible Party.** If this or a separate OC SURGICAL Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as a financially responsible party, you hereby guarantee the full and prompt payment to OC SURGICAL of all indebtedness of patient to OC SURGICAL, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by OC SURGICAL in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness.

This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of OC SURGICAL at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of the financially responsible party. I certify that I have read and fully understand, or have had explained to my satisfaction, the above statements. By my signature, I hereby affirm to all of the terms and conditions set forth in the above paragraphs and agree to be bound by this contract.

_________________ ____________________________________________

(Date) (Patient, Parent/ Guardian or Party Responsible)

1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

SECOND FOLD

WHCF-10-ENV / WHCF-10-ENV-SS

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | NPI | |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

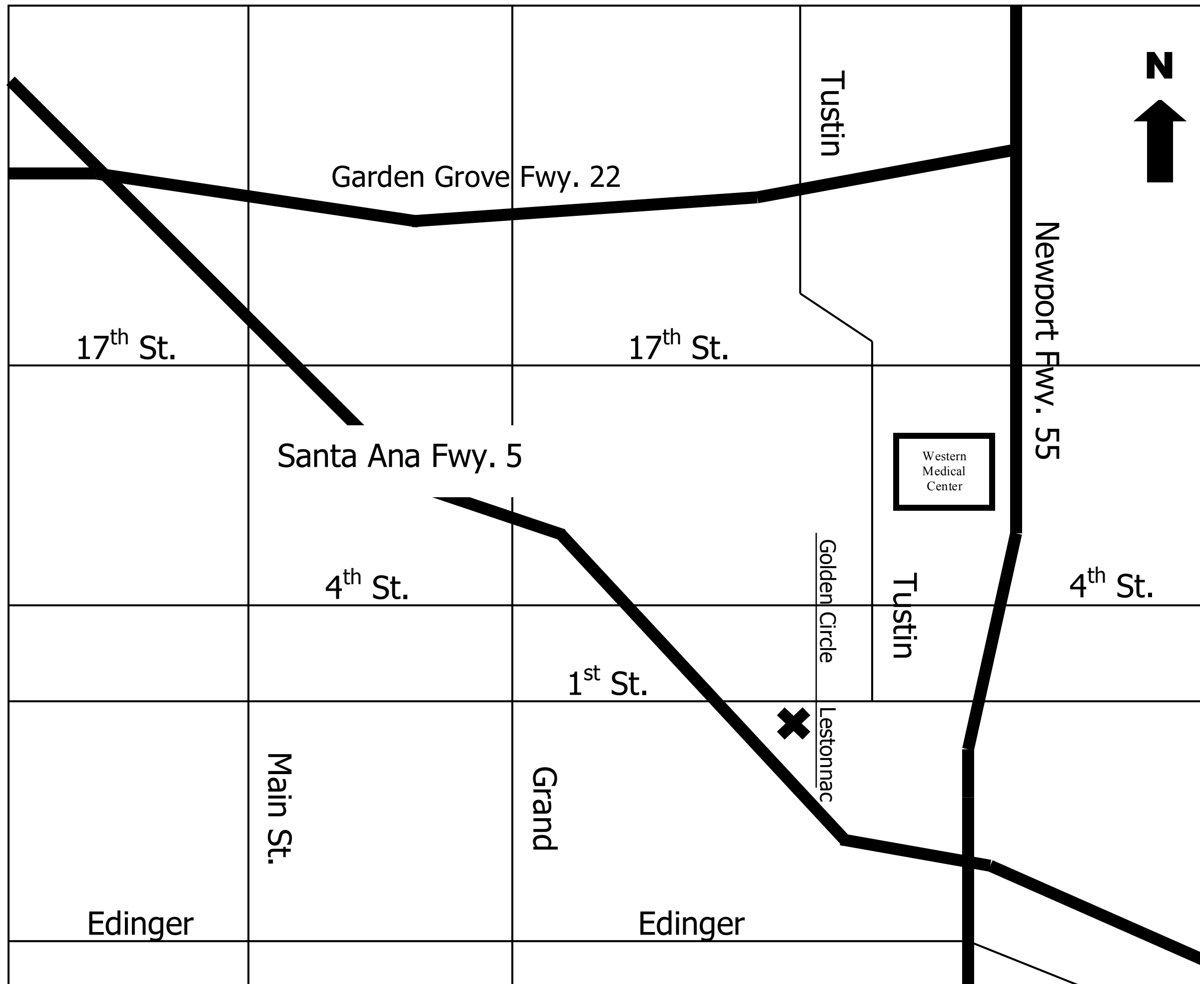
a. b.

# Map & Directions

**Your appointment:**

**Date: ______________ Time: __________**

2010 East First St. Suite 160 • Santa Ana, CA • 92705 • Office: 714-647-1200




**FROM ANAHEIM**:
South on Santa Ana FWY – 5
Exit 4th Street/Irvine Blvd– Turn Left
Turn right at Golden Circle Dr.
Continue on Golden Circle Dr. to enter First Street Medical Plaza
Turn right into parking lot

**FROM CORONA:**
West on 91 FWY to 55 FWY South (Newport Beach)
Exit 4th Street/Irvine Blvd – Turn Right
Turn left at Tustin Ave.
Turn right at 1st Street
Turn left at Lestonnac Dr./Golden Circle Dr.
Turn right into parking lot

**FROM FULLERTON**:
East on 91 FWY to 55 FWY South (Newport Beach)
Exit 4th Street/Irvine Blvd – Turn Right
Turn left at Tustin Ave.
Turn right at 1st Street
Turn left at Lestonnac Dr./Golden Circle Dr.
Turn right into parking lot

**FROM LONG BEACH:**
East on Garden Grove FWY – 22 to 5 FWY South
Exit 4th Street/Irvine Blvd – Turn Left
Turn right at Golden Circle Dr.
Continue on Golden Circle Dr. to enter First Street Medical Plaza
Turn right into parking lot

**FROM NEWPORT BEACH:**
North on Newport Beach FWY – 55
Exit 4th Street/Irvine Blvd – Turn Left
Turn left at Tustin Ave.
Turn right at 1st Street
Turn left at Lestonnac Dr./Golden Circle Dr.
Turn right into parking lot

**FROM SAN DIEGO:**
North on 5 FWY toward Santa Ana
Exit 4th Street/Irvine Blvd – Turn Left
Keep left at the fork and merge onto Mabury St.
Turn left at First Street
Turn right at Lestonnac Dr. to enter First Street Medical Plaza
Turn right into parking lot