SHARPER VISION CENTERS

PATIENT INFORMATION

First Name ▲ | Middle Initial ▲ | Last Name ▲ | Nick Name/AKA ▲

Date of Birth | Email | Female/Male Gender

Home Address | City | State | Zip Code

Home Phone | Work/Day Phone | Mobile Phone | Home-Mobile-Work/Day Preferred Number (circle)

Race (optional) ☐ Asian ☐ Hispanic ☐ White Non-Hispanic ☐ Native Hawaii or Pacific Islander ☐ American Indian/ Alaska Native ☐ Black or African American ☐ Other

RESPONSIBLE PARTY / WHO TAKES CARE OF YOUR BILLS

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Last Name ▲ | First Name ▲ | Middle Initial ▲

Home Adress | Apt# | City | State | Zip Code

Home Phone | Work/Day Phone | Mobile Phone | Home-Mobile-Work/Day Preferred Number (circle)

EMERGENCY CONTACT

Name:_____

Relationship:_____

Phone: _____

How did you hear about Dr. Oyakawa?

☐**Friend?** _____ ☐**Phone Book?**_____

☐**Newspaper?**_____ ☐**Internet?**_____

PHYSICIAN INFORMATION

Primary Care Physician | Phone Number

Referring Physician | Phone Number

INSURANCE INFORMATION - PLEASE PROVIDE COPY OF INSURANCE CARDS

Primary Insurance:

☐ Medicare ☐ Private Insurance Name of Insurance: _____

Name of Insured | DOB of Insured | Relationship To Insured

_____ _____ ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance:

Name of Insurance: _____

Name of Insured: | DOB of Insured | Relationship To Insured

_____ _____ ☐ Self ☐ Spouse ☐ Parent

Financial Agreement and Authorization for Treatment

PAYMENT POLICY

We accept Cash, Checks, Debit Cards w/ VS or MC logo, and Major Credit Cards. Patients with Private insurance or with no insurance coverage are required to pay in full at the time of service. We require insurance deductibles to be paid at the time of service. Insurance deductibles sometimes are not known at the time of service, we will bill you for these after your insurance has paid. However, we reserve the right to collect known deductibles at the time of service.

Returned checks are subject to bank service charges up to $35.00.

As a courtesy, we will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Prompt payment of any amounts due after your insurance has paid is necessary. For any procedures requiring out-patient or in-office lasers, you will be responsible for payment if your insurance has not paid at 60 days.

Unpaid accounts are considered delinquent after 90 days may be subject to collections. Patient will be responsible for all costs involved, including collection agency fees and interest.

I, _____ hereby authorize payment of medical benefits to Sharper Vision Centers AMG Inc. (SVC) for services rendered to me. I further agree to pay all non-covered services or charges at time of service. If my insurance pays me directly for unpaid balances to SVC, I agree to pay SVC immediately or my account will be considered delinquent and may be subject to collections.

ACCESS TO YOU MEDICAL RECORDS

Your medical records are available to you via our internet patient portal at no charge. Log in at https://portal.sharpervisioncenters.com:7510/ If you require printed copies of your records, SVC may charge up to $50.00 + mailing fees.

PATIENT CONSENT FOR TREATMENT, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Sharper Vision Centers AMG Inc. physicians and assistants to treat me. SVC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. Sharper Vision Centers AMG Inc Notice of Privacy Practices provides a more complete description of such uses and disclosures. SVC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained upon request.

_____ _____

Signature of Patient (or Legal Guardian) Date

_____

Print Patient's Name (Print Name of Legal Guardian)

(06252018)

MEDICAL RELEASE OF INFORMATON AUTHORIZATION

Release of Information

I authorize the release of information including appointments, diagnosis, records, examinations, claims and account information to:

Name/Relationship	Phone
_____	_____
_____	_____
_____	_____

[ ] DO NOT release information to anyone.

[ ] Ok to release information to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages I Prefer you call me at …

List in order of preference

[1] _____

[2] _____

[3] _____

_____ _____

Signature of Patient (or Legal Guardian) Date

_____

Print Patientôs Name (Print Name of Legal Guardian)

(07012020)

Patient Email and Text Messaging Consent

Your health care is important to us. In order to provide you with the best possible care, we send convenient text messages and/or emails to our patients about:

- *Appointment confirmations and reminders*
- *Wellness check-ups*
- *Prescription notifications*
- *Account information*

**You will not receive text messages/emails about marketing or promotions.*

You are currently not set to receive text messages/emails from Sharper Vision Centers. Please pick an option below.

_____ *I consent to receive text messages and/or emails.*

*Cell Phone #*_____

Email _____

_____ *I decline to receive text messages/emails from Sharper Vision Centers.*

_____ _____

Print Name (patient/legal guardian) *Date*

_____

Signature (patient/legal guardian

We look forward to providing better and more convenient communications with you via text messaging/emails. Thank you

Sharper Vision Centers, A Medical Group, Inc. 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. You have the right to obtain a copy of this Notice upon request.

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information without your permission.

Example of Treatment, Payment, and Health Care Options

Treatment:

We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care.

Payment:

We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of the payments from your health plan.

Health Care Operation:

We will use and disclose your health information to conduct standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses:

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you.

Other Uses and Disclosures:

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information approved for medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to the public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths of coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workersô compensation or similar programs providing benefits for work-related injuries or illness.

In any other situations, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any future uses or disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using a postcard to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. A fee may apply.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of this Notice currently in effect.

Changes in Privacy Policies

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Ann Quinonez
20911 Earl Street #240A
Torrance, CA 90503
(310) 792-1010
Effective Date: April 14, 2003

SIGN HERE ↓

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practice given to me.

NOTICE TO PATIENTS

OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

You may search this federal database for payments made to physicians and teaching hospitals by visiting this website:

https://openpaymentsdata.cms.gov/

SHARPER VISION CENTERS

Patient History Form

Name_____ **Date**_____

What's the primary reason for today's visit?

_____

1. Are you experiencing any of the following symptoms? (Please circle all that apply)

Eye pain Discharge Light Sensitivity Decreased Vision Dry Eyes
Double Vision Floaters Flashes of light Glare - day or night

2. Do you have any problems with your current glasses or contact lenses? Please describe _____

_____

3. Date most recent glasses or contacts were prescribed mm/dd/yy _____

4. Are you diabetic? _____ **If so, who is your endocrinologist?** _____ **Phone:**_____

What type of diabetes (circle) Type I Type II

5. Have you ever had an eye injury or eye condition? Please describe

_____

6. Have you ever had **EYE surgery**? Please list date, circle eye and type of surgery

Date: _____ Eye: Right/Left _____

Date: _____ Eye: Right/Left _____

7. Are you currently taking **EYE medications**? Please list names and dose _____

8. Are you **allergic** to **any** medications? Which? And Reaction? _____

9. **Women –** Are you pregnant or Nursing? _____

10. **Men** – Have you ever or currently taking "prostate medication" like FLOMAX/Rapaflo or Alpha- blockers? List Medication & how long ago?

_____

11. Do you keloid (scar tissue overgrowth) after healing from cut or surgery? **Yes / No**

Please circle any of the following that you would like to discuss with you doctor today

Glaucoma	Modern Cataract surgery	Retina Diseases	Intraocular Lens Implants: Crystalens, Trulign, Multifocals
Macular Degeneration	Diabetic Eye Disease	LASIK	

(02/13/19)

Patient History Form (cont.)

Name: _____ **Date** _____

Are you being treated for?

Condition	Yes	No
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Thyroid Disease	☐	☐

Other_____

Have you had any general surgeries? Describe_____

_____

Current Medications/Vitamins & Dose (Rx or Over Counter) or provide list

1_____
2_____
3_____
4_____
5_____
6_____
7_____
8_____
9_____
10_____

Review of Systems: Do you presently have any problems in the following area?

	Yes	No	Explain
General health	☐	☐	_____
Skin	☐	☐	_____
Eyes	☐	☐	_____
Ears	☐	☐	_____
Nose	☐	☐	_____
Mouth/Throat	☐	☐	_____
Neck	☐	☐	_____
Respiratory	☐	☐	_____
Cardiovascular	☐	☐	_____
Gastrointestinal	☐	☐	_____
Genito-urinary	☐	☐	_____
Musculoskeletal	☐	☐	_____
Neurological	☐	☐	_____
Endocrine	☐	☐	_____
Hemato-Immunologic	☐	☐	_____
Psychiatric	☐	☐	_____

Reviewed by: _____

Family Medical History:

Yes	No	Who? father, mother, brother/sister
☐	☐	Glaucoma/_____
☐	☐	Retina Disease/_____
☐	☐	Macular Degeneration/_____
☐	☐	Blindness/_____
☐	☐	Diabetes/_____
☐	☐	Arthritis/_____
☐	☐	Hypertension/_____

Other:
_____

Social History (circle all that apply)

Alcohol	None Occasionally Socially Weekends Decline to answer
Smoking	Never Former Smoker Everyday Some days Decline to answer
Diet	No Particular Diet Balanced Diet Low Car Low Sodium Other_____
Lifestyle	High Stress Lifestyle Moderate Stress Lifestyle Low Stress Lifestyle
Exercise	None Minimal Regular Active Other_____
Occupation	Full-Time Part-Time Retired Decline to answer Title/Type of Work _____
Street Drug Use	No use of street drugs Used Street Drugs before but Quit Occasionally Decline to answer
Sexual Activity	Widowed Monogamous Married Single Inactive Other_____ Decline to answer