



20072 SW Birch St., Ste 240, Newport Beach, CA 92660

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_ Birth State: \_\_\_\_\_

Birth Sex: Male  Female  Preferred Method of Contact: Email  Home Phone  Cell Phone

Preferred Language: English  Armenian  Spanish  Other  \_\_\_\_\_

Race: American Indian or Alaska Native  Asian  Black or African American   
Native Hawaiian or Pacific Islander  White  Decline to Answer  Other  \_\_\_\_\_

Ethnicity: Hispanic or Latino  Not Hispanic or Latino

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_  
(cross streets and/or city)

How did you hear about us? \_\_\_\_\_

PCP: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Phone: \_\_\_\_\_

Medical Insurance: Yes  (Please provide insurance cards) No

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home/Cell/Work Phone (circle one): \_\_\_\_\_ Release Medical Information: Yes / No (circle one)

I authorize EyeWellMD and its healthcare providers to perform medical examinations, diagnostic procedures, and treatments deemed necessary for my care. I authorize the release of any prior results or images as needed to assist with my diagnosis and plan of care. A copy of this authorization may be used in place of the original. I understand that I am personally responsible for all charges for services rendered, including copays, deductibles, and any balances not covered by my insurance. Copays and deductibles are due at the time of service. While EyeWellMD will bill my insurance as a courtesy, I acknowledge that I am responsible for any unpaid balances.

**Text Message (SMS) Communication Consent**

Yes, I consent to receive appointment reminders, care-related communications, and billing notifications from EyeWellMD via text message at the cell phone number I have provided. Message and data rates may apply. I understand that I may opt out of receiving text messages at any time by notifying the office.

No, I do not consent to receive text messages.

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date

# EYEwell MD

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of birth _____	Date of last eye exam _____
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Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD /LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

## FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

<p>Has any member of your family had these diseases? Circle all that apply.</p> <p>Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other: _____</p>
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## SOCIAL HISTORY

<p>Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?    YES    NO</p> <p>Have you ever had a blood transfusion?    YES    NO</p> <p>Do you drink alcohol? YES    NO    If YES, how much? _____</p> <p>Do you smoke? YES    NO    If YES, how much? _____ How many years? _____</p>
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### Eye History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing EyeWellMD for your eye care. To better serve you, please answer the following questions:

- 1. Do you wear glasses?  Yes  No
- 2. Do you wear contact lenses?  Yes  No
- 3. Do you have problems reading?  Yes  No

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

- Light Sensitivity
  - Blurred Vision
  - Eyelid Crusting
  - Flashes of Light
  - Halos
- Discharge
  - Eye Pain
  - Double Vision
  - Decreased Vision
  - Floaters

5. Have you ever had an eye injury? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

\_\_\_\_\_ R / L      Date: \_\_\_\_\_  
\_\_\_\_\_ R / L      Date: \_\_\_\_\_

7. Are you currently using eye medications? Please list name and how often used:

\_\_\_\_\_  
\_\_\_\_\_

8. Are you being treated for medical conditions? Please circle all that apply:

- Diabetes
  - Heart Disease
  - High Blood Pressure
  - High Cholesterol
- Stroke
  - Arthritis
  - Other: \_\_\_\_\_

9. What medications are you taking? Please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you allergic to any medication? Please list: \_\_\_\_\_

11. Do you have a family history of eye problems? Please list family relationship:

Glaucoma \_\_\_\_\_      Cataract \_\_\_\_\_  
Retinal Disease \_\_\_\_\_      Macular Degeneration \_\_\_\_\_

12. Please circle any of the following that you would like more information about:

- Diabetic Eye Disease
  - Dry Eyes
- Macular Degeneration
  - Glaucoma
  - Other: \_\_\_\_\_



## **PATIENT FINANCIAL RESPONSIBILITY POLICY**

Thank you for choosing EyeWellMD. We are committed to providing you with the highest quality medical care. This policy explains your financial responsibilities and helps ensure clear communication.

### **INSURANCE & BILLING**

We bill insurance as a courtesy; however, verification of benefits is not a guarantee of payment. Insurance coverage is a contract between you and your insurance carrier.

- **Patient Responsibility:** Patients are responsible for all copays, deductibles, coinsurance, non-covered services, and denied claims.
- **Payment Due:** Copays are due at the time of service.
- **Insurance Information:** Patients are responsible for providing accurate and current insurance information and for obtaining any required referrals or prior authorizations.

### **NON-COVERED SERVICES**

Certain services may not be covered by insurance, including refractions, contact lens evaluations, refractive surgery consultations, and cosmetic services. Payment for these services is due at the time of service.

### **SELF-PAY PATIENTS & GOOD FAITH ESTIMATE**

If insurance coverage cannot be verified or if we do not participate with your plan, you will be considered self-pay. Payment in full is due at the time of service.

#### **Your Right to a Good Faith Estimate:**

Under the No Surprises Act, uninsured or self-pay patients have the right to receive a Good Faith Estimate explaining how much their medical care will cost before services are provided.

- We will provide this estimate in writing at least 1 business day before your service.
- You may also request a Good Faith Estimate before scheduling a service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you may dispute the bill.
- For more information, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).



#### PAYMENT POLICY

Payment is due at the time of service unless prior arrangements are made. We accept cash and credit cards. Please note that we cannot provide change for cash payments. Any overpayment will be applied to your account as a credit for future use.

- **Credit Card on File:** A credit card may be required to be kept on file to cover patient responsibility balances, including copays not collected at the time of service, outstanding balances, and missed appointment fees.
- **Missed Appointments:** Appointments canceled with less than 24 hours' notice or missed appointments may result in a \$75 no-show fee. This fee is not billable to insurance.
- **Collections:** Patient responsibility balances not paid within 90 days may be referred to collections as permitted by California law.

#### CALIFORNIA CONSUMER DEBT DISCLOSURE

- **In compliance with California law,** medical debt will not be reported to consumer credit reporting agencies.
- **Mandatory Language:** A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. If violated, the debt shall be void and unenforceable.
- **Refunds:** Overpayments or duplicate payments will be refunded in accordance with California law after insurance processing is complete.

#### AUTHORIZATION & ACKNOWLEDGMENT

I authorize the release of medical information necessary to process insurance claims and assign insurance benefits directly to the provider.

I have read and understand this financial policy and agree to its terms.

Patient or Authorized Representative Name: \_\_\_\_\_

Patient or Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EyeWellMD  
20072 SW Birch Street, Suite 240  
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Phone: 949-590-8808  
Fax: 949-590-8870  
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### Acknowledgment Of Privacy Practices

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I acknowledge that I have received a copy of the Notice of Privacy Practices from EyeWellMD and hereby give consent to EyeWellMD to use and disclose my protected health information as described in the Notice.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

\_\_\_\_\_  
Name and Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name, Signature & Relationship of Patient Representative  
(Required if patient is a minor or an adult unable to sign form)

\_\_\_\_\_  
Date

**The following individuals have my authorization to access my Protected Health Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date of Birth

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## Patient's Rights And Responsibilities

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Individuals receiving services at EyeWellMD have both rights and responsibilities. These rights include the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. You may also ask for a copy of these rights at any time.

### Your Rights:

1. The right to be treated with consideration and respect for personal dignity and privacy.
2. Services without discrimination of race, religion, sex, ethnicity, age, sexual orientation, disability or cultural background.
3. The right to be informed of your condition and proposed treatment.
4. Opportunity to refuse any services after explanation of what the services entails and the expected outcome.
5. The right to receive treatment in the least restrictive environment available with reasonable protection from harm.
6. The right to file a grievance and do so without retaliation.
7. The right to request a change of provider if there is another provider available that can address your issues.
8. The right to review and modify your protected health information.
9. The right to request a copy of your health care information for as long as the information is retained.
10. The right to request EyeWellMD restrict the use and disclosure of your confidential health care information.
11. To receive a copy of the notice of EyeWellMD's HIPAA privacy practices.
12. To request a list of when and to whom your health care information was released without your authorization.

### Your Responsibilities:

1. To be considerate and respectful towards staff, and the rights of other clients/patients.
2. To be honest regarding matters that relate to you.
3. To report changes in your condition.
4. To cancel or reschedule your appointment if you know that you will not be able to keep it.
5. To meet financial obligations agreed to with EyeWellMD.

**I have read and understand the above Rights and Responsibilities.**

\_\_\_\_\_  
Signature of Patient or Legally Responsible Person

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Relationship/Reason Why Patient Is Unable to Sign

\_\_\_\_\_  
Date

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### Consent For E-Prescribing

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ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent you are agreeing that EyeWellMD can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above I hereby provide informed consent to EyeWellMD to enroll me in the ePrescribe program. This consent will remain in effect until revoked or changed.

\_\_\_\_\_  
Patient Signature or Authorized Person

\_\_\_\_\_  
Patient's Name or Authorized Person

\_\_\_\_\_  
Date

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### Consent - Dilating Eye Drops

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Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Elda Aghaian, MD and/or such assistants as designated by Elda Aghaian, MD to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

\_\_\_\_\_  
Patient Signature or Authorized Person

\_\_\_\_\_  
Patient's Name or Authorized Person

\_\_\_\_\_  
Date

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**Request for Access and Authorization for Use and/or  
Disclosure of Protected Health Information**

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Please allow a minimum of seven business days to process your request.

I authorize: \_\_\_\_\_ to

**Disclose to** EyeWellMD via fax, mail, or pick-up.

**Obtain from**

Access and/or disclosure of the following records for the dates of service: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Check appropriate boxes below:**

- |   |   |
|---|---|
| <input type="checkbox"/> Summary of Record: Dictated Reports, Laboratory Reports, Testing Reports | <input type="checkbox"/> Alcohol/Drug Treatment/Testing |
| <input type="checkbox"/> Billing Records  | <input type="checkbox"/> HIV/AIDS Related Information   |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Genetic Testing                |
| <input type="checkbox"/> Operative Reports  | <input type="checkbox"/> Pathology Reports              |
| <input type="checkbox"/> Laboratory results   | <input type="checkbox"/> Radiology Reports              |
| <input type="checkbox"/> Mental health Testing/Treatment  | <input type="checkbox"/> Diagnostic Images              |
|   | <input type="checkbox"/> Other _____                    |

I understand that the protected health information may include mental health, substance abuse (e.g., drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. I have read and understand the following statements:

1. I understand that EyeWellMD may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, EyeWellMD will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
3. I understand that EyeWellMD will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.
4. I understand that I may revoke this Authorization at any time by notifying EyeWellMD in writing, but if I do, it will not have any effect on any actions EyeWellMD took before it received the revocation.
5. I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.

6. I understand that by specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
7. Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
8. I understand requests may be subject to an administrative fee.
9. I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by EyeWellMD.
10. I understand this Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ or when the following event occurs: \_\_\_\_\_ . If no expiration date, event or condition is noted, this authorization will expire 1 year from the date signed.

I understand it is my responsibility to notify EyeWellMD to initiate follow-up requests based upon this standing authorization.

\_\_\_\_\_  
Patient Signature or Authorized Person

\_\_\_\_\_  
Patient's Name or Authorized Person

\_\_\_\_\_  
Date

**Name of Facility to Request Records From:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax