Inland Eye Institute
Medical Group, Inc.
Inland Eye LASIK

Thank you for choosing us!

Our physicians and staff are committed to providing you with excellent care. Since this may be your first visit to our office, we would like to make the process as stress free as possible.

In order to make your first appointment go as smoothly as possible, please **complete** the enclosed forms **prior** to your appointment and bring them with you for your appointment on

Date: _____ Mon Tue Wed Thu Fri

Time: _____ am / pm *PLEASE ARRIVE 15 MINUTES EARLY*

Doctor: Blanton Kim Roe Sanchez Tabandeh Vidor

Appointment length varies by doctor and medical condition.
Please be prepared to spend between 1 and 3 hours in our office.

You also need to bring:

1. Insurance card or proof of insurance.
2. Picture I.D. with current address.
3. Name of your current pharmacy, address and phone number.
4. If you are a new patient, you may be dilated and will need to bring a driver.
5. Co-payment or Deductible (payment is due at time of service).

Please call **(909) 825-3425** at least **48 hours in advance**
if you are unable to keep this appointment.

We appreciate your assistance and look forward to being your eye care provider.

** *Should you arrive without insurance information, you could be responsible for payment at the time of service.*

(PLEASE PRINT)

PATIENT INFORMATION: Today's Date _____ Acct.# _____

Patient_____
Last First Middle

Address_____

City and State _____ Zip_____

Cell Phone (_____) _____ Home Phone (_____) _____ Marital Status_____

Date of Birth _____ Age _____ Male ❒ Female ❒ Social Security # _____

Driver's Lic. #_____ E-mail Address _____

Can we E-mail information to you periodically? Yes ❒ No ❒

Employer _____ Work Phone _____

IN CASE OF EMERGENCY: Name _____ Phone # _____

PHARMACY: Name _____ Phone # _____

RESPONSIBLE PARTY if other than patient:

Name _____ Social Security #_____

Address _____ Driver's Lic. #_____

Employer _____ Telephone_____

ACCIDENT: Industrial/Work Related? Yes ❒ No ❒ Auto Accident? Yes ❒ No ❒

Did you come through Emergency Room? Yes ❒ No ❒ Other Accident? Yes ❒_____

Date of injury _____ Has employer been notified? _____ Has carrier been notified? _____

HOW WERE YOU REFERRED TO THIS OFFICE?

❒ Internet ❒ Friend/Patient ❒ Other (Specify) _____

❒ Physician/Optometrist: _____
Name Address

MEDICAL INSURANCE INFORMATION: (Attach copy of cards)

(1) <u>PRIMARY Insurance Co.</u>: _____ Group/Policy #_____

Policy Holder _____ Member/ID#_____

Policy Holder Date of Birth _____ Policy Holder Male ❒ Female ❒

Patient Relationship to Policy Holder _____

Referring Medical Physician _____ Referring Medical Group_____

(2) <u>SECONDARY Insurance Co.</u>:

Insurance Company _____ Group/Policy #_____

Policy Holder _____ Member/ID#_____

Policy Holder Date of Birth _____ Policy Holder Male ❒ Female ❒

Patient Relationship to Policy Holder _____

Review of Systems

Inland Eye Institute
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Please list medications you are taking, including eye drops:

→		→	
→		→	
→		→	
→		→	

Do you currently have any of the following problems? If "yes", please explain.

1.	Do you have any allergies to any medication?	❒ Yes ❒ No	
2.	**General Health:** (fever, weight loss, other)	❒ Yes ❒ No	
3.	**Eyes:** (glaucoma, cataract, lazy eye, retina problems, other – please specify)	❒ Yes ❒ No	
4.	**Ear/nose/mouth/throat:** (hearing loss, sinus problems, sore throat)	❒ Yes ❒ No	
5.	**Cardiovascular:** (heart problems, chest pain, irregular heart beat, high BP)	❒ Yes ❒ No	
6.	**Respiratory:** (asthma, shortness of breath, wheezing, coughing)	❒ Yes ❒ No	
7.	**Gastrointestinal:** (heartburn, abdominal pain, diarrhea, vomiting)	❒ Yes ❒ No	
8.	**Genital/kidney/bladder:** (urinary problems, blood in urine)	❒ Yes ❒ No	
9.	**Skin:** (skin rashes, excessive dryness, cancer)	❒ Yes ❒ No	
10.	**Musculoskeletal:** (muscle aches, joint pain, swollen joints)	❒ Yes ❒ No	
11.	**Neurological:** (numbness, weakness, headaches, paralysis)	❒ Yes ❒ No	
12.	**Blood/lymph:** (blood disorders, leukemia)	❒ Yes ❒ No	
13.	**Allergic/Immunologic:** (hay fever, allergies)	❒ Yes ❒ No	
14.	**Endocrine:** (thyroid problems, diabetes)	❒ Yes ❒ No	
15.	**Psychiatric:** (depression, anxiety)	❒ Yes ❒ No	

Family & Social History: Do any medical or eye diseases run in your family? ❒ Yes ❒ No
If "yes", please note relationship to patient.

❒ Glaucoma	_____	❒ Macular degeneration	_____
❒ Diabetes	_____	❒ Other _____	_____
❒ High blood pressure	_____	❒ Other _____	_____

Do you smoke? ❒ Yes If "yes", how much? _____ ❒ No
Drink alcohol? ❒ Yes If "yes", how much? _____ ❒ No
Flu shot (influenza vaccine)? ❒ Yes If "yes", when? _____ ❒ No
Pneumococcal vaccine? ❒ Yes ❒ No

_____
Patient Signature Date

_____
Physician Signature Date

Patient Information

Signature on File, Assignment of Benefits, Financial Agreement

_____ _____

Beneficiary Name *(print)* Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Inland Eye Institute, for services furnished me by Inland Eye Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Inland Eye Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Inland Eye Institute, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Inland Eye Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Inland Eye Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. Inland Eye Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Inland Eye Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Inland Eye Institute has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Inland Eye Institute if I belong to a plan that does not appear on the above mentioned list.

5**. NON-COVERED SERVICES:** I understand that Inland Eye Institute's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Inland Eye Institute to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Inland Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Inland Eye Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Inland Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Inland Eye Institute*. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

X_____ _____

Beneficiary Signature or Authorized Party Date

FINANCIAL POLICY

Welcome and thank you for choosing us as your eye care provider. We are committed to providing you the finest care and service.

FINANCIAL RESPONSIBILITY: You are responsible for payment of all charges associated with your visit. As a courtesy, and for your convenience, we bill your insurance company when you have provided us with all the requested insurance information. You are responsible for your deductible, co-payment, co-insurance, and non-covered service at the time the services are rendered. If uncertain of your coverage, please contact your insurance company. If you choose not to bill your insurance for care provided, it is understood that you assume financial responsibility for all charges.

METHOD OF PAYMENT: We accept cash, check, Visa, MasterCard, and American Express, Discover and CareCredit.

PATIENT BILLING: Patients who have outstanding balances are billed monthly. All balances are due within 30 days from the billing date. All outstanding balances must be paid prior to any future services being rendered.

RETURN CHECKS: A $25.00 fee is charged for all returned checks.

I clearly understand and agree to the provisions of this financial policy:

Patient Name: _____

Signature of Responsible Party: _____

Date: _____

*Please present your Driver's license and insurance information to the receptionist.

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IEI
Inland Eye LASIK

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. The law does not require Inland Eye Institute (IEI) to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment and health care operations. You have the right to revoke this Acknowledgement, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. IEI provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment or health care operations.
- Protected Health Information (PHI) may also be disclosed to the following person(s):

  _____
- IEI has a Notice of Privacy Practices and that describes how PHI might be used. The patient has the opportunity to review the Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to request a restriction on the release of their information; the law does not require IEI to agree to those restrictions.
- IEI may condition treatment upon the execution of this Acknowledgement.

This Acknowledgement was signed by: _____
Signature

Please also print the name of the person signing the form: _____

Relationship to Patient (if other than patient): _____

Date: _____

In front of: _____
Printed Name – Practice Representative

Directions to
INLAND EYE INSTITUTE and
SAN BERNARDINO EYE SURGERY CENTER

We are located at 1900 E. Washington Street in Colton.

If you are coming from the **Los Angeles area**, take the 10 Freeway East to the 215 Freeway South. Exit on Mt. Vernon/Washington. This is a circle exit so stay in the right lane. As you come over the overpass of the 215 Freeway merge to the left lane. Continue approximately one-half mile. We are on the right-hand side of the street.

If you are coming from the **Riverside area**, take the 91 Freeway East. The 91 Freeway turns into the 215 Freeway North. Take the 215 Freeway North to the Mt. Vernon/Washington exit and turn left at the first stoplight. Proceed to Washington Street and turn right. Continue approximately one-half mile. We are on the right-hand side of the street.

If you are coming from the **Redlands area,** take the 10 Freeway West to the 215 Freeway South. Exit on Mt. Vernon/Washington. This is a circle exit so stay in the right lane. As you come over the overpass of the 215 Freeway merge to the left lane. Continue approximately one-half mile. We are on the right-hand side of the street.

If you are coming from the **San Bernardino area,** take the 215 Freeway South and exit at Mt. Vernon/Washington. This is a circle exit so stay in the right lane. As you come over the overpass of the 215 Freeway merge to the left lane. Continue approximately one-half mile. We are on the right-hand side of the street.

Inland Eye Institute
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Colton, California 92324
(909) 825-3425 (800)794-2020
Fax (909) 825-4778

San Bernardino Eye Surgery Center
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Fax 909-424-1662

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