Registration : **Kavita Surti Md Inc**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I, the undersigned, certify that I (or my dependant) have insurance with _____ I assign directly to CITRUS VALLEY EYECARE all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for ALL charges whether or not paid by any Insurance and/or any charges incurred during collection action. I hereby authorize CITRUS VALLEY EYECARE to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.
I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Kavita Surti Md Inc	
X		475 W Badillo St Covina, CA 91723	Phone: 626-732-2200 Email:

Please attach all pertinent insurance ID cards for photocopying.

Citrus Valley Eyecare 475 W. Badillo Street Covina CA 91723 Phone (626)732-2200 Fax (626)732-2900

Name:_____Date:_____

Date of **Birth**:_____ Date of **last eye exam**:_____
Do you have any **allergies** to medications? **YES**_____ **NO** _____
Do you use any medications if YES then list them:_____
_____
_____
_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, cholesterol, COPD, arthritis)
_____
List any **surgeries** you have had (cataract, appendectomy, ect.): _____

Do you ***currently*** have any problems in the following areas? **If YES**, please provide additional information.

	NO	**YES**	**Details**
EYES(poor vision, eye pain, tearing, redness ect)			
GENERAL/CONSTITITIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, ect.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, ect.)			
CARDIOVASCULAR (High BD, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, ect.)			
GASTROINTESTINAL(stomach upset, diarrhea, constipation, hernia, ulcers, ect.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, ect.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, ect.)			
SKIN (pimples, warts, growth, rash, ect.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, ect.)			
PSYCHIATRIC (anxiety, depression, insomnia, ect.)			

FAMILY HISTORY

Has any member of your family had these diseases (circle all that apply) ?
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, ect.)? **YES○ NO○**
Do you drink alcohol? ……**YES○ NO○** If YES, How much?_____
Do you smoke?……**YES○ NO○** If YES, How much?_____ How many years?_____
Do you use recreational drugs? **YES○ NO○** If YES, What drug?

Physician Signature_____
Date:_____

CITRUS VALLEY

EYECARE

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings. **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

_____

Patient Signature Date Physician Signature

PATIENT PORTAL

Our offices strive to provide you the best quality care. When you come in for a visit, we wish to provide you with our undivided attention. During office hours, our providers are in the midst of seeing patients, where communication is vital to a patient-provider relationship. When calls are made into the office, messages are taken and then handled via our staff or the providers. Often at the end of a busy day we may have twenty or more messages awaiting us. Most messages are simple and can be handled immediately; others are more detailed and require a bit more time. If you factor in the difficulty of returning calls and the inability to get in touch with the patient, this "phone tag" system can greatly complicate matters.

In order to make communication easier and more effective, we have installed a **PATIENT PORTAL, A WEB BASED COMMUNICATION SYSTEM.** Through the portal, and email system, we can document and exchange messages, offer refill requests, and answer pre and postop questions and send educational material. We will highly recommend that everyone register for this portal. Communication via the portal will get priority and most times can be handled within the same day or next day. The web portal is to be used for non-emergent matters.

I have read the above and consent to use of the portal.

_____ _____

Signature Email

SMS TEXT MESSAGING

I **DO** give my written consent for **Citrus Valley Eyecare** to text me on my cell phone regarding appointment reminders, test results or any miscellaneous communication.

_____

Patient Signature Date Cell Phone Number

I **DO NOT** give my written consent for **Citrus Valley Eyecare** to text me on my cell phone regarding appointment reminders, test results or any miscellaneous communication.

_____

Patient Signature Date

CITRUS VALLEY
EYECARE

FINANCIAL POLICY

We would like to thank you for choosing Citrus Valley Eyecare as your eyecare provider. We are committed to providing you quality and efficient eyecare with a smile. In an effort to provide you with the best possible experience during your office visit, we have developed this policy which details our financial requirements to help you understand your responsibilities as a patient.

Insurance Benefits/Deductibles: Knowing your insurance benefits, including co-pays, co-insurances and yearly deductibles is your responsibility and these are to be paid at time of visit. If you have a yearly deductible that has not been met, a deposit towards that visit will be collected at the time of visit. If there is a remainder balance for your visit, once we receive the explanation of benefits, you will be responsible for the balance immediately. **Initials _____**

Copayments: All co-payments are due at time of visit. **NO EXCEPTIONS!** If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you. **Initials _____**

Health Plans and Coverage: The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. Any and all authorizations for HMO plans is your responsibility, if the health plan denies your claim for lack of authorization, the full payment will be your responsibility. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Current Information: We require you to bring your insurance card with you to **every** office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

Forms: There will be a charge for filling out forms based on your medical records. Fees vary based on the form. Please ask the receptionist at Citrus Valley Eyecare.

Records and Copying: There will be a $20 charge for copying medical records. A records release will be needed.

Returned Check Fee: There is a $30 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment at any time on your account in the future.

Cancellation/No Show Policy: We understand that there may be times when you miss an appointment due to emergencies. We **URGE** you to call **24 hours** prior to cancelling your appointment. Failure to do so may result in a charge of **$25.00.** If you "no show" for two consecutive appointments or cancel for a total of four appointments without notification, you **WILL** be discharged from care.

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines: YES/NO

_____ _____

Signature of patient or responsible Party Date