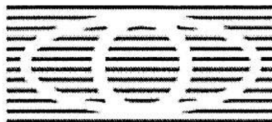


TURNER EYE INSTITUTE

PATIENT INFORMATION

LAST NAME	FIRST NAME		M.I.	SOCIAL SECURITY # - -	IS RESPONSIBLE PARTY THE PATIENT? ☐ YES ☐ NO	
HOME ADDRESS			DRIVER'S LICENSE NUMBER		AGE	SEX ☐ MALE ☐ FEMALE
CITY	STATE	ZIP	HOME PHONE ( ) -		DATE OF BIRTH / /	
EMPLOYER			OCCUPATION		IS YOUR COMPANY PART OF THE CORPORATE EDGE PROGRAM? ☐ YES ☐ NO	
WORK ADDRESS			EMAIL ADDRESS		MARITAL STATUS	
CITY	STATE	ZIP	WORK PHONE ( ) -		FAX NUMBER ( ) -	

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US? ☐ DOCTOR ☐ EXISTING PATIENT ☐ OTHER ____________________

NAME OF REFERRING PATIENT	ADDRESS	PHONE ( ) -
NAME OF REFERRING DOCTOR	ADDRESS	PHONE ( ) -

EMERGENCY CONTACT (nearest relative not living with you)

NAME	PHONE ( ) -	ADDRESS	RELATIONSHIP

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	MEMBER # / MEDICARE NO.	NAME OF SECONDARY INSURANCE	MEMBER # / MEDICARE NO.
NAME OF PERSON RESPONSIBLE	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY:

PLACE COPY OF MEDICAL CARD HERE

MEDICAL RELEASE AUTHORIZATION

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regards to processing my claims. I request that payment of authorized Medicare, Medical or insurance benefits be made directly on my behalf to Turner Eye Institute Medical Group. I further request that any supplemental insurance benefits be paid also as stated above. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

SIGNATURE____ DATE____________________
PATIENT/RESPONSIBLE PARTY

San Leandro • Santa Clara • Concord
420 Estudillo Avenue, San Leandro, CA 94577-4989
Chirag R. Patel, MD • Stephen G. Turner, MD FACS • Rosalia Saavedra, OD
(800) 339-2733 www.turnereye.com

HEALTH QUESTIONNAIRE/ALLERGIES AND SENSITIVITIES

1. **Date of last eye exam:** ______________________ **Doctor:** ________________________________

2. **Is there a history of skin reaction or other unusual reaction or sickness following injection or oral administration of:**

	Circle One			What drug or food?
Penicillin or other antibiotics	Yes	No	Don't know	____________
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't know	____________
Novocain or other anesthetics	Yes	No	Don't know	____________
Aspirin, Empirin or other pain remedies	Yes	No	Don't know	____________
Sulfa drugs	Yes	No	Don't know	____________
Tetanus antitoxin or other serums	Yes	No	Don't know	____________
Adhesive tape	Yes	No	Don't know	____________
Iodine or merthiolate	Yes	No	Don't know	____________
Any other drug or medication	Yes	No	Don't know	____________
Any foods such as egg, milk, chocolate	Yes	No	Don't know	____________

3. **Drugs Recently Taken:** Within the past six months have you taken:

Cortisone	Yes	No	Don't know
Thyroid Medications	Yes	No	Don't know
Anticoagulants (blood thinners)	Yes	No	Don't know
Tranquilizers	Yes	No	Don't know
Hypotensives (high blood pressure medicines)	Yes	No	Don't know
Aspirin	Yes	No	Don't know
Other	Yes	No	Don't know What? __________

Have you ever received treatment for asthma, rheumatism or rheumatic fever? (shortness of breath)

☐ No ☐ Yes If yes, please list: ______________________________

4. **What other medical conditions are you being treated for?** ______________________________

____

____

5. **What operations have you had?** ______________________________

6. **Have you ever had eye surgery?** ☐ No ☐ Yes If yes, please list: ______________________________

7. **Have you ever been told you had any of the following?** (Circle where appropriate)

	Patient		Blood Relative	
Macular Degeneration	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No
Cataracts	Yes	No	Yes	No
Dry Eyes	Yes	No	Yes	No
Retinal Detachment	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Hypertension	Yes	No	Yes	No
Heart Problems	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Bleeding Tendency	Yes	No	Yes	No

8. **Do you have any of the following?** (Check all that apply)

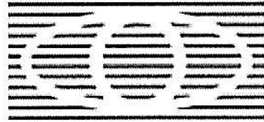
- ☐ Blurred vision at distance
- ☐ Blurred vision at near/reading
- ☐ Floaters
- ☐ Pain in the eyes
- ☐ Redness in the eyes
- ☐ Double vision
- ☐ Can't see well with present glasses
- ☐ Eyes are sore or dry
- ☐ Eyes water excessively
- ☐ Halo effect
- ☐ Other (describe): ______________________________

____

____

____

9. **Have you noticed a recent change in your vision?** ☐ Yes ☐ No



TURNER EYE INSTITUTE
420 Estudillo Avenue
San Leandro, CA 94577

Acknowledgement of Receipt of Notice of Privacy Practices

Office Manager/Privacy Officer: 510-614-1515

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 I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________________ Date: __________________________

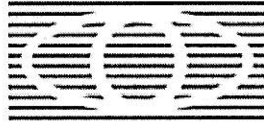
Print Name: __________________________ Telephone: _____________________

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ________________________________



TURNER EYE INSTITUTE

420 Estudillo Avenue
San Leandro, CA 94577

Notice of Privacy Practices

Office Manager/Privacy Officer: 510-614-1515

Effective Date: April 10, 2003

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 of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients

of health care information are prohibited from re-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 efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. 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. We may mail a postcard reminding you of an appointment.

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. Notification 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 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. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

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 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. We reserve the right to accept or reject your 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 e-mail 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 and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, 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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

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 16 (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 a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

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 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 will offer you a copy at each appointment. 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:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.