Patient Name: _____ **Date:** _____

Ophthalmology Associates of the Valley

Patient History Record

Please answer the following questions about your medical status and history:

1. Your reason for today's visit. Briefly explain any current eye problems.

_____

_____

_____

☐ Routine exam-no particular problems. (Your insurance may not cover routine exams!)

☐ Referred by physician _____

☐ Possible medical or surgical problem _____

☐ Considering contact lenses _____

☐ Considering laser vision correction _____

☐ Other _____

2. Please check if you are currently having any of the following eye problems:

☐ Pain ☐ Burning, itching or scratching sensation ☐ Redness ☐ Tearing ☐ Discharge ☐ Seeing in dim light
☐ Blurred or Fuzzy Vision ☐ Double Vision ☐ Problems with glasses ☐ Tired Eyes ☐ Poor Night Vision
☐ Flashing lights ☐ Cobwebs, dark spots or dark veils ☐ Headaches ☐ Halos around lights ☐ Glare

3. Please check any of these eye problems that you have had in the past:

☐ Cataract ☐ Glaucoma ☐ Macular Degeneration ☐ Eye injury ☐ Eye surgery ☐ Retina problem
☐ Muscle Imbalance ☐ Double vision ☐ Floaters ☐ Flashing lights

4. Date of your last eye examination: _____ Who performed the exam? _____

5. Do you now wear glasses? ☐ Yes ☐ No ☐ Distance ☐ Reading ☐ Computer ☐ Sunglasses

6. Do you currently wear contact lenses? ☐ Yes ☐ No ☐ Hard ☐ Gas Permeable ☐ Soft ☐ Disposable?
Contact Lens Solution (name?) _____

7. Please write down anything else you may wish the doctor to know:

_____

_____

_____

_____

_____

Please complete the reverse side of this page!

General Medical History

Please answer the following questions about your medical status and history:

1. Have you ever been treated for: ☐Diabetes ☐High blood pressure ☐Rheumatoid arthritis ☐Lupus ☐Stroke ☐Cancer (type?) _____ ☐Asthma ☐Thyroid Disease ☐Heart Disease ☐HIV Infec

Additional information: _____

2. Have you ever had any surgery? ☐Yes ☐No If YES, please provide dates and type of surgery:

_____

_____

_____

2. Please list any hospitalizations, dates and reason: _____

_____

4. Do you take any medications? ☐Yes ☐No If yes, please list: _____

_____

5. Do you take any eye drops? ☐Yes ☐No If yes, please list: _____

6. Are you allergic to any medications? ☐Yes ☐No If yes, please list: _____

Review of Systems

Do you currently have any of the following problems:	Yes	No	If Yes, please explain:
Chronic fever, unexpected weight loss, fatigue	☐	☐	
Ear, nose, throat problems, sinusitis, hearing loss	☐	☐	
Heart problems, chest pain, irregular heart beat	☐	☐	
Respiratory problems, wheezing, cough, shortness of breath	☐	☐	
Gastrointestinal problems, diarrhea, vomiting, heartburn, pain	☐	☐	
Urinary problems, pain, discharge, blood in urine, urgency	☐	☐	
Skin problems, acne, seborrhea, eczema, psoriasis, rashes	☐	☐	
Musculoskeletal problems, aching, joint pain, joint swelling	☐	☐	
Neurologic symptoms, numbness, weakness, headaches	☐	☐	
Psychiatric problems, depression, anxiety, agitation	☐	☐	
Endocrine problems, thirst, temperature intolerance	☐	☐	

Family and Social History:

Please check if any of the following conditions are in your family: ☐Glaucoma ☐Strabismus ☐Retinal Disease ☐Cataract

Diabetes ☐Hypertension ☐Heart Disease ☐Cancer ☐Other: _____

Please check the habits that apply: ☐Smoke? If yes, how much? _____ ☐Alcohol? If yes, how many drinks? _____

What is your occupation? _____

I enjoy the following hobbies (golf, reading, fishing, swimming, etc.):

1. _____ 2. _____ 3. _____

Other comments:

_____

Physician Signature Date

Ophthalmology Associates of the Valley

PATIENT REGISTRATION FORM

Mr. Mrs. Miss Ms_____ Today's Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Your Home Phone:_____ Your Work Phone:_____

Your Cell Phone:_____

Name of employer:_____ Occupation:_____

Sex: M F Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed

Social Security Number: ___-___-___ Date of Birth:__/__/__ Age:_____

Drivers License #_____ Exp. Date _____

E-mail:_____

❑ I would like to receive information regarding appointments, health & eye disorders, updates on our practice, services, specials or monthly newsletters by email (you can unsubscribe at anytime).

Patient Spouse:_____ Spouse Work Phone:_____

If Patient is a minor, Please provide name of Parent/Guardian: _____ Phone: _____

Referred by:_____ Phone: _____

❑ Doctor ❑ Optometrist ❑ Existing Patient ❑ Family Member ❑ Co-Worker ❑ Friend
❑ Yellow Pages ❑ Internet ❑ Other

Family Physician:_____ Phone: _____

Emergency Contact Name_____ Phone: _____

Government regulations contained in the Patient Protection Affordable Care Act have mandated that we collect the following additional demographic information.

1. Preferred Language:_____

2. Race (please check appropriate box below)

❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American

❑ White or Caucasian ❑ Native Hawaiian or other Pacific Islander ❑ Other Race ❑ Decline to answer

3. Ethnicity (please check appropriate box below)

❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Unknown ❑ Decline to answer

(PLEASE COMPLETE REVERSE SIDE)

Ophthalmology Associates of the Valley

Insurance: Please list the subscriber of the policy if other than the patient. List your primary insurance company first.

PRIMARY HEALTH

1._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

SECONDARY HEALTH

2._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

VISION PLAN

3._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

Please Read and Initial:

I authorize the release of any medical information necessary to process all claims.
____ Initial

I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.
____ Initial

I understand that I am responsible for payment on my account for any non-covered items.
____ Initial

I request that the payment of authorized insurance benefits be made on my behalf to **Ophthalmology Associates of the Valley, Peter D. Zeegen, M.D., David H. Aizuss, M.D., Brad S. Elkins, M.D., Stanley M. Kopelow, M.D., Stan Saulny, M.D., Mark H. Kramar, M.D.,** for services furnished to me by that supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information to determine these benefits payable for related services.
____ Initial

REFRACTION SERVICE AND FEE

One of the most important parts of your eye exam today is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is payable at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have completely read all the above information and agree to all the terms.

_____ _____

Signature of patient or person acting on patient’s behalf Date

Any information that we collect about you on this form will be kept confidential in our offices.

OPHTHALMOLOGY ASSOCIATES OF THE VALLEY
PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, wouid be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Acknowledgement of Receipt of Notice of Privacy Practices

Ophthalmology Associates of the Valley

Office Manager Encino office: 818-990-3623

Office Manager West Hills office: 818-346-8118

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.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

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

Name of Patient: _____

We're Giving your Prescription a "Head Start" Before you ever leave the office

Our practice can send prescriptions electronically to local pharmacies that are connected to the Pharmacy Health Information Exchange, Operated by SureScripts. Instead of a paper prescription, we can send the same information directly to the pharmacy computer.

That means a safer and more efficient prescribing process for you.

- **No More Lost Prescriptions**
- **No trip to the pharmacy to drop off the prescription**
- **No illegible handwriting for the pharmacist to interpret**

We Think you'll agree, it's a better way to fill your prescriptions.

In order to start we need to have your Pharmacy information;

Patient Name_____

Patient Home Zip Code_____

D.O.B. _____ M/F_____

PHARMACY Name _____

PHARMACY Address_____

PHARMACY City _____State____Zip code_____

PHARMACY Phone_____3-15-10

Peter D. Zeegen, M.D.,F.A.C.S.
David H. Aizuss, M.D.,F.A.C.S
Brad S. Elkins, M.D.,F.A.C.S.
Stanley M. Saulny M.D.,F.A.C.S.
Stanley M. Kopelow, M.D.
Mark H. Kramar, M.D. F.A.C.S

Ophthalmology Associates of the Valley (OAV) offers its patients the ability to communicate with us via electronic mail (e-mail) over the Internet.
If you have an Internet e-mail address and would like to take advantage of this service, please discuss your wishes with your doctor.
Some doctors prefer not to communicate with their patients over the Internet.
If we agree to exchange e-mail with you, please observe the following:

E-mails Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
   - Do not use e-mail to send or request very sensitive information. OAV cannot and does not guarantee the confidentiality of any messages being sent over the Internet.
   - Messages can be misdirected or intercepted by unintended parties.
   - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
   - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
   - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date, home addreess or your medical record number

If you do not provide this information, your healthcare provider may not to be able to respond. In order to protect your confidentiality do not place name, date of birth or medical record number in subject line.
If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address that we provided, please call our office to verify you have the correct address and that the e-mail system is functioning properly.
If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call our office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.
I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.
I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

_____
Signature of Patient or Legal Representative

_____
Patient Name

_____
Email

_____
Date

Comprehensive Ophthalmology, Laser and Refractive Surgery, Cataract Surgery, Corneal Transplantation, Glaucoma and Glaucoma Surgery, Ophthalmic Plastic, Reconstructive, Lacrimal and Orbital Surgery, Diseases and Surgery of the Vitreous and Retina, Diabetic Retinopathy