PABALAN EYE CENTER
6900 Brockton Ave. Ste 203, Riverside, Ca 92506

Please complete the enclosed forms prior to your appointment and bring them with you on_____ for your _____ appointment.

PLEASE ARRIVE FIFTEEN MINUTES PRIOR TO APPOINTMENT TIME

In addition to your completed forms, bring the following to your appointment:

1. Insurance card
2. Picture I.D. with current address
3. Current pharmacy name, address and phone number.
4. Co-payment or Deductible (payment is due at time of service).
5. If you are a new patient, please bring a driver. Your eyes may be dilated.
6. A list of all your medications.
7. Prescription eye drops

We accept the following forms of payment:

- Cash
- All major credit cards and Care Credit
- Checks

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

If you arrive without insurance information, you will be responsible for payment at the time of service.

If you are unable to keep this appointment, please call our office at least twenty four hours in advance. We understand that delays can happen, however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment, if prior notice of possible delay is not given. Our office number is (951)682-4353.

P A B A L A N E Y E C E N T E R

Please Turn Off Your Cell Phone

PATIENT INFORMATION:

Mr. / Mrs. / Ms. / Miss / Dr. or Military Rank _____ Branch of Service: USAF / USMC / USA / USN / USCG

Name: _____ /_____/_____

FIRST MI LAST

Home Phone: (____)_____ Cell Phone: (____)_____

Home Address: _____City:_____ State: ___ Zip:_____

Email Address :_____

Social Security Number: _____- _____ - _____ Date of Birth:____/____/_____ Marital Status: S M D W

Who is your regular Medical Doctor or PCP _____

Driver's License # / State:_____

Parent / Guardian / Power of Attorney: _____

Who may we contact in case of emergency?_____ Phone: _____

To whom we may release information about you?

1)_____ Relationship:_____

2)_____ Relationship:_____

3)_____ Relationship:_____

RESPONSIBLE PARTY: Who is responsible for payment of your bill? (Circle "MYSELF" if applicable) MYSELF

Name: _____ / _____ / _____

FIRST MI LAST

Their relationship to you:_____

RESPONSIBLE PARTY'S INSURANCE INFO:

Primary Insurance:_____

*Secondary Insurance:*_____

Subscriber Name: _____

Subscriber's Date of Birth: _____

Responsible Party must know the Insurance Benefits and Coverage, whether a referral is required, and if Pre-Certification is needed for procedures or surgery.

NOTIFY US OF ANY CHANGE TO INSURANCE PLAN OR COVERAGE.

PHARMACY INFORMATION:

Name and Address of your preferred Pharmacy _____:

OFFICE POLICIES:

Our doctors can provide your care only after you have reviewed office policies and signed these forms. Thank you.

- **Cell phone use is not allowed inside the office.** Please step outside if you must use your phone.
- ***Patient or Responsible Party must know their Insurance Benefits and Coverage, whether a referral is required, and if Pre-Certification is needed for procedures or surgery.***
- ***NOTIFY US IMMEDIATELY OF ANY CHANGE TO INSURANCE PLAN OR COVERAGE.***

CANCELLATION OR FAILURE TO SHOW FOR APPOINTMENTS

If you need to cancel an appointment, we require **notification at least 24hrs prior** to the appt time. Failure to give adequate notice or to keep your appointment will result in a **Cancellation/ No Show fee** charge of $30.00. We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is **15 minutes past their scheduled time we may have to reschedule** the Appointment if prior notice of possible delay were not given.

A.) REFILLING OF PRESCRIPTION MEDICATIONS:

All medication refill requests are to be made in a timely manner. Please do not wait until you are out of drops or medicines! Our office will comply with your request in a timely manner but processing your request can take up to 72 hrs. Certain medications require monitoring, if you do not keep appointments we may not be able to refill your medications until you have been seen by our office.

X_____ DATE_____

Patient / Guardian Signature

B.) ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance coverage with the above named insurance(s) and assign directly to Dr. Pabalan all medical benefits, if any, otherwise payable to me for services rendered. I understand that I bear final responsibility for all charges. I understand that insurance does not pay for all costs, even for some care that you and your doctor may decide is needed.

For all reasonable costs of collection if my account becomes delinquent, I hereby authorize the doctor to release all information necessary to get payment of benefits. I authorize the use of this signature on all my insurance submissions, paper or electronic.

X_____ DATE_____

Signature of Insured / Guardian

C.) MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Pabalan.
I authorize any holder of medical information about me to be release to the Health Care Financing Administration 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 HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X_____ DATE_____
Medicare Beneficiary Signature

D.) NOTICE OF PRIVACY PRACTICES (HIPAA) INFORMATION

I, the undersigned, hereby acknowledge that I have been given access to a copy of the Notice of Privacy Practices. The Notice of Privacy Practices is available online at www.pabalaneyecenter.com and you have the right to obtain a paper copy of this notice from us by request, even if you have agreed to accept this notice electronically. Furthermore, I understand that my information will not be released or sold, under any circumstances. My information, including that which pertains to medications or appointments WILL NOT be shared with others, including family members, unless I have listed them on the front of the form. Please direct any questions to our Privacy Officer, Francisco J. Pabalan, M.D. at 951-682-4353 or email at ivcmain@yahoo.com.

X_____ DATE_____
Patient/ Guardian Signature

E.) PERMISSION TO LEAVE MESSAGES VIA EMAIL, TEXT OR PHONE:

I, the undersigned, grant permission to Pabalan Eye Center to do its best to leave messages and information for me, including messages regarding my medical care, and appointments, by Email, Text, or Phone.

F.) ATTENDANT / RESPONSIBLE PARTY:

Attendant or responsible party is required to remain with the patient at all times and throughout the exam.

HOWEVER, AS A COURTESY TO OTHER PTS, WE ASK THAT NO MORE THAN ONE PERSON ACCOMPANY THE PATIENT WHILE IN THE WAITING ROOM OR EXAM ROOM.

I understand the policies above and wish to receive services from Pabalan Eye Center.

X_____ DATE_____
Patient/ Guardian Signature

PABALAN EYE CENTER

-- HEALTH HISTORY --

HAVE YOU EVER HAD Cataract Surgery? Right eye _____ DATE:_____ **Left Eye**_____ DATE: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

Yes No Diabetes - how long?_____
Yes No Do you use Insulin? _____ Yrs.
Last A1C value_____
Yes No Kidney Disease
Yes No Sickle Cell Anemia
Yes No Seasonal Allergies
Yes No Venereal Disease _____
Yes No Blood Disease _____
Yes No Skin Disease_____
Yes No HIV
Yes No (Women) Are you pregnant?

Yes No Stroke
Yes No Migraines
Yes No High Blood Pressure
Yes No Heart Problems
Yes No Lung Disease
Yes No Tuberculosis
Yes No Asthma
Yes No High Cholesterol
Yes No Arthritis
Yes No Cancer, of_____

ANY EYE PROBLEMS:

	YOU	IN YOUR FAMILY (WHO?)
Cataracts	Y N	Y N_____
Glaucoma	Y N	Y N_____
Macular Degeneration	Y N	Y N_____
Diabetic Retinopathy	Y N	Y N_____
Retinal Detachment	Y N	Y N_____
Crossed/Turned Eyes	Y N	Y N_____
Hereditary Eye Problems	Y N	Y N _____

ARE YOU ALLERGIC TO ANY MEDICINES OR EYEDROPS?

YES NO

If **YES**, please list:

_____
_____
_____

Do you smoke? Yes No
If yes, how many packs per day?_____
/ year
How many years of smoking?_____
What is your **occupation?** _____

Alcohol Intake:
None or #____drinks per day / week / month

OPERATIONS OR SERIOUS INJURIES:

DATE	REASON OR CAUSE
_____	_____
_____	_____
_____	_____
_____	_____

Any Other Illness or Medical Information:

WHAT MEDICATIONS DO YOU TAKE REGULARLY?

NAME OF MEDICINE	WHAT FOR	NAME OF MEDICINE	WHAT FOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____