

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.

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 will have to reschedule the Appointment, if prior notice of possible delay is 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! 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, and for all reasonable costs of collection should my account become delinquent. I hereby authorize the doctor to release all information necessary to secure 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 _____
Patient/ Guardian Signature

DATE _____

E.) PERMISSION TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE:

I, the undersigned, grant permission to Pabalan Eye Center to leave messages and information, including messages regarding my medical care, on my phone machine at the home phone number given above.

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 _____
Patient/ Guardian Signature

DATE _____

www.pabalaneyecenter.com

02/15/2011

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	Stroke
Yes	No	Do you use Insulin? _____ Yrs.	Yes	No	Migraines
		Last A1C value _____	Yes	No	High Blood Pressure
Yes	No	Kidney Disease	Yes	No	Heart Problems
Yes	No	Sickle Cell Anemia	Yes	No	Lung Disease
Yes	No	Seasonal Allergies	Yes	No	Tuberculosis
Yes	No	Venereal Disease _____	Yes	No	Asthma
Yes	No	Blood Disease _____	Yes	No	High Cholesterol
Yes	No	Skin Disease _____	Yes	No	Arthritis
Yes	No	HIV	Yes	No	Cancer, of _____

Yes No (Women) Are you pregnant? _____

ANY EYE PROBLEMS:

<u>EYEDROPS?</u>	<u>YOU</u>	<u>IN YOUR FAMILY (WHO?)</u>	ARE YOU ALLERGIC TO ANY <u>MEDICINES</u> OR
Cataracts	Y N	Y N _____	YES NO
Glaucoma	Y N	Y N _____	If YES, please list:
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 _____	

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
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Any Other Illness or Medical Information:

WHAT MEDICATIONS DO YOU TAKE REGULARLY?

NAME OF MEDICINE	WHAT FOR	NAME OF MEDICINE	WHAT FOR