DANIEL C. KLINE, MD, INC
3500 BARRANCA PARKWAY SUITE 290
IRVINE CA 92606-8277

Thank you for choosing our office!

Date:

***Please print-** *All information will be strictly confidential.*

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I.:	GENDER M-F / MARITAL STATUS M S W D / AGE
ADDRESS:			
CITY, STATE:		ZIP:	DATE OF BIRTH: / /
HOME PHONE:	CELL PHONE:	WORK PHONE	
EMPLOYER:		OCCUPATION:	
IF CHILD, PARENT OR GUARDIAN'S NAME:			SOCIAL SECURITY
PARENT OR GUARDIAN'S D.O.B.:		E-MAIL ADDRESS:	
SPOUSE:		SPOUSE'S D.O.B.:	SPOUSE'S PHONE NUMBER:
WHOM MAY WE THANK FOR REFERRING YOU:		❑PHYSICIAN ❑WEBSITE ❑FRIEND/ RELATIVE ❑INSURANCE PLAN ❑OTHER: ______	

PERSONAL INSURANCE INFORMATION

(PLEASE COMPLETE SO WE MAY BILL YOUR INSURANCE)

PRIMARY INSURANCE PLAN:

POLICY HOLDER'S NAME:	POLICY HOLDER'S D.O.B.:
RELATIONSHIP TO PATIENT:	POLICY HOLDER'S SSN#:

SECONDARY INSURANCE PLAN (*OR VISION INSURANCE):

POLICY HOLDER'S NAME:	POLICY HOLDER'S D.O.B.:
RELATIONSHIP TO PATIENT:	POLICY HOLDER'S SSN#:

NAME OF NEAREST RELATIVE OR FRIEND

NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

NAME:	PHONE #:
ADDRESS:	RELATIONSHIP:

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

I hereby authorize Daniel Kline MD, Inc. to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor(s) all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. On balances not paid within 90 days, I will be responsible for interest and penalties incurred at 7%. A $35 cancellation fee will be issued for no-shows and cancellations less than 24 hours in advance. A service charge of $25 will be issued for returned checks. A service charge of $35.00 will be issued for reprinted refund checks.

Patient's signature ______________________________

(*OR PARENT/GAURDIAN IF PATIENT IS A MINOR)

PATIENT HISTORY QUESTIONNAIRE

Last Name:_____________________________________ First Name:___________________ Middle Initial:__

Date of last eye exam:____________ Dilated: Yes / No (circle one) Today's Date: ___________________

MEDICAL INFORMATION

What is your general health?____

Do **you** have problems with any of these systems? (Please circle all that apply)

Gastrointestinal	Nervous	Eyes	Mental	Ear/Nose/Throat	Genitourinary
Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Endocrine(glands)	Cardiovascular	Musculoskeletal	Blood/Lymph	Respiratory	Skin
Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Allergic/Immunologic: Y/N

Please explain any Yes answers above:____

Please answer all that apply: Diabetes: Y/N Type:____ Date of Diagnosis:_______________

Allergies? Y/N To What?___________________ What happens?_______________________________

Medication Allergies? Y/N What Medicine?___________ What happens?__________________

Current Medications:____

Have you had any operations? Y/N Kind?_______________________ When?________________________

Do you use?	Cigarettes	Tobacco	Alcohol	Other Substances?	What:
	Y/N	Y/N	Y/N	Y/N	______________

Name of Family Doctor:____________________________ Date of last visit:_____________________________

Date of last tetanus shot: __________ Headaches: Y/N

FAMILY HISTORY

High Blood Pressure: Y/N
Who?_______________________

Macular Degeneration: Y/N
Who?_______________________

Diabetes: Y/N
Who?__________

Cataracts: Y/N
Who?________

Retinal Detachment: Y/N
Who? _______________________

Glaucoma: Y/N
Who?__________

Other Eye Conditions: Y/N
Type:____

PERSONAL EYE INFORMATION (pertaining to YOUR EYES only)

Operations: Y/N Type:__________ Date:__________ Injury: Y/N Type: __________ Date:________

Glaucoma: Y/N Cataracts: Y/N Dry Eye: Y/N Macular Degeneration: Y/N

Other Eye Problems: Y/N Type:____

Do you wear: Eye Glasses? Y/N Contact Lenses? Y/N Type:________________________

Whom may we thank for your referral: ____

Would you like to learn more about any of the following: (Mark all that apply)
LASIK _____ BOTOX_________ LATISSE ___________

A. Notifier: Daniel C. Kline MD, Inc.

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Insurance doesn't pay for **D.** Service below, you may have to pay.

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for the **D.** Service below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
Refraction (*Eyeglass prescription exam)	**Non-covered by most medical insurance plans**	**$75.00**

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **D.** Service listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐**OPTION 1.** I want the **D. Service** listed above. You may ask to be paid now, but I also want Insurance billed for an official decision on payment, which is sent to me on an Explanation Of Benefits (EOB). I understand that if Insurance doesn't pay, I am responsible for payment, but **I can appeal to Insurance** by following the directions on the EOB. If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐**OPTION 2.** I want the **D. Service** listed above, but do not bill Insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance is not billed**.

☐**OPTION 3.** I don't want the **D. Service** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice or Insurance billing, please call your health plan.

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Your Eyeglass Prescription...

At **OC Eye Associates** you will receive excellent complete eyecare, and will benefit from the latest technologies to improve and enhance your vision. Dr. Kline is a comprehensive ophthalmologist who specializes in the care of not only the health of your eyes, but also in the treatment of your vision. In addition to performing surgery for cataract and LASIK, Dr. Kline can prescribe and fit eyeglasses and contact lenses. It is our goal to provide exceptional service to you, and in order to ensure we meet or exceed your expectations, we would like to offer assistance in regards to your vision needs. As you may already know, vision coverage is usually separate from your medical coverage. Many patients have separate vision insurance. As our office is contracted with several different vision plans, we would be happy to verify whether you have benefits available toward vision examinations for eyeglasses or contact lenses. These types of vision examinations (also called refractions) are helpful in evaluating the overall health of your eyes, and are typically recommended annually if you wear glasses or contacts. Our office charges a $75.00 fee should you choose to have this service done as part of your comprehensive eye examination. If you believe you have separate vision insurance that covers this service, please provide the name of your plan along with the primary subscriber's name and identification number so we can assist you in obtaining authorization and coverage information. We look forward to seeing you for your next eye examination!

Thank You!

~Dr. Kline and Staff

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

Treatment Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your identifiable health information in order to write a prescription for you, or we might disclose your identifiable health information to a pharmacy when we call and order a prescription for you. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children, or parents.

Payment Our practice may use and disclose your identifiable health information, as needed, in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

Health Care Operations Our practice may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice. We may use your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect, Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; Workers Compensation; inmates; required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of House and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures These will be made only with your consent and with authorization of opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION
You have the following rights regarding the identifiable health information that we maintain about you:

Confidential Communication You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your

care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspection and Copies You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Our practices may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

Amendment You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures All of our patients have the right to request an accounting of disclosure. An accounting of disclosure is a list of certain disclosures our practice has made of your identifiable health information. All requests for an accounting of disclosure must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice You are entitled to receive a paper copy of our notice of privacy practices.

Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Video and/or audio recordings on a closed circuit security system may be taken for security and healthcare operations (e.g. quality assurance) purposes.

If you have any questions, requests or complaints regarding this notice of our health information privacy policies, please discuss with the doctor.

We are required by law to maintain the privacy of individuals and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information

By signing this form, you consent to our use and disclosure of protected information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Print Name: ____________________________ Signature: ___________________________Date: ____________

v. 6/2015