NORTH BAY EYE ASSOCIATES

Welcome to North Bay Eye Associates!

We are looking forward to meeting you at your scheduled appointment. At the time of your appointment please bring the following information with you:

- Completed forms
- Current medical and vision insurance cards
- Current glasses (even if broken)
- Current contact lens information and packaging if available
- List of all oral medications and bring any eye drop bottles that you are currently using
- Minors must be accompanied by parent or legal guardian

We request that you kindly give us 24 hours notice if you are unable to keep your appointment. Should you arrive more than 15 minutes late of your scheduled appointment, you may be delayed or asked to reschedule depending on other patients waiting for our services.

Our entire office staff would like to welcome you to our office as well as thank you for selecting us to serve your vision care needs. We look forward to providing you with the personal and professional vision care you deserve.

Please feel free to call us with any questions you may have concerning your vision care.

Sincerely,

North Bay Eye Associates, Inc.

Office Procedures

If this is your first visit to our office or you are scheduled for a dilated eye exam, please plan to be in our office for at least 1 ½ hours. The dilation process in children often takes up to 45 minutes. Therefore, please plan 2 hours for children's eye exams. Due to the fact that your eyes will remain dilated after your visit, please be sure to bring sunglasses with you.

After your initial visit, an appointment card will be provided to you. We make every effort to see you at the time of your appointment. Please remember, however, that sometimes situations beyond our control will arise causing us to be delayed. If, for any reason, we are running behind, we will do our best to keep you informed. If this occurs and you are unable to wait, please inform our receptionist and we will reschedule at the earliest appointment time that we have available to accommodate you.

PAYMENT IS DUE AND PAYABLE AT THE TIME THAT THE SERVICES ARE PROVIDED, UNLESS YOU ARE A MEMBER OF A HEALTH PLAN OR PREFERRED PROVIDER ORGANIZATION TO WHICH WE BELONG. If you are a member of such an organization, payment of your co-pay, deductible and/or co-insurance is due at the time of service. *Failure to pay your copayment at the time of service will result in a $15 service charge being added to your account.* For non-fixed co-payment plans, a minimum of 20% of the total visit fee is due at the time of service. Unaccompanied minors should be provided with the appropriate payment or co-payment. Payment may be made by cash, check or accepted credit cards.

All returned checks are subject to a $25.00 processing fee.

Past Due Accounts

We will make every effort to work with you in payment of past due balances. However, past due accounts for which no mutually agreed payment arrangements have been made for payment will be turned over to a collection agency.

Contact Lens Fittings

On your initial visit, the doctor will perform a complete, comprehensive eye examination to determine the health of your eyes. If the doctor determines you to be a candidate for contact lenses, a SEPARATE fitting appointment will be scheduled at an additional charge. If you are an existing contact lens wearer who has purchased your lenses elsewhere or wishes to change the type of lens you are wearing, a SEPARATE appointment will be scheduled to evaluate and refit your lenses at an additional charge.

Missed Appointments

Patients who fail to keep appointments or who do not give us 24 hours notice to reschedule the appointment are subject to pay a fee. After consecutive missed appointments, we will ask you to seek medical care elsewhere. Patients who arrive 15 minutes or more after their scheduled appointment time may be asked to reschedule.

Telephone Calls

Please call the office if you have any questions regarding your treatment or medication. Our office personnel can often assist in arranging for prescription refills as well as help answer any questions that you may have. If no one is available when you call, we will do our best to return your call in a timely fashion. Please allow 24 hours for prescription refills. Thank you.

NORTH BAY EYE ASSOCIATES PATIENT REGISTRATION

NAME:		DATE:
BILLING ADDRESS:	CITY, STATE	ZIP CODE
STREET ADDRESS:	CITY, STATE	ZIP CODE

DOB:	SOCIAL SECURITY #	DRIVER'S LICENSE #

GENDER: ☐ MALE ☐ FEMALE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ DOMESTIC PARTNER

RACE: ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN/ALASKA ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ DECLINE TO STATE

NATIVE ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO STATE

PRIMARY LANGUAGE:	OTHER COMMUNICATION: ☐ YES ☐ NO IF YES, PLEASE LIST:

IF PATIENT IS A MINOR, THE FOLLOWING MUST BE COMPLETED:

FINANCIALLY RESPONSIBLE PARTY:	RELATIONSHIP TO PATIENT:	SOCIAL SECURITY #
ADDRESS (IF DIFFERENT FROM PATIENT'S):	CITY, STATE	ZIP CODE

ALL PATIENTS AND/OR RESPONSIBLE PARTIES PLEASE COMPLETE THE FOLLOWING:

EMPLOYER:	OCCUPATION:	BUSINESS PHONE:
BUSINESS ADDRESS:	CITY, STATE	ZIP CODE

CONTACT INFORMATION:

HOME #:	OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	How would you like to be contacted regarding your appointments? ☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-mail
WORK #:	OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	
CELL #:	OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	
E-MAIL ADDRESS:		

INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE COMPANY:	POLICY/ID#	RELATIONSHIP TO POLICYHOLDER: ☐SELF ☐SPOUSE ☐PARENT ☐OTHER_____
NAME OF SECONDARY INSURANCE COMPANY:	POLICY/ID#	RELATIONSHIP TO POLICYHOLDER: ☐SELF ☐SPOUSE ☐PARENT ☐OTHER_____

PLEASE COMPLETE IF POLICY HOLDER LISTED ABOVE IS ANYONE OTHER THAN "SELF":

NAME:	SOCIAL SECURITY #	DOB:

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME:	PHONE #

INSURANCE ASSIGNMENT AND RELEASE:

I hereby assign all medical, vision, and/or surgical benefits to which I am entitled including Medicare, Private Insurance, and other Health Plans to North Bay Eye Associates. I understand that since the services were provided to me, I am ultimately financially responsible for all charges whether or not paid by insurance. 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. This assignment will stay in effect until revoked by me in writing.

SIGNATURE_____DATE: _____

RELATIONSHIP TO THE PATIENT: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

PLEASE COMPLETE IF PATIENT IS UNDER 18:

In case of my absence, I hereby give permission to North Bay Eye Associates for treatment as they deem necessary to my child.

SIGNATURE:_____DATE: _____

RELATIONSHIP TO THE PATIENT: ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN

PRIVACY NOTICE AND ADVANCED DIRECTIVE ACKNOWLEDGMENT:

I hereby acknowledge that a copy of North Bay Eye Associates, Inc. Notice of Privacy Practices and an Advanced Directive Brochure have been made available to me to review and that a copy of each is available at my request.

SIGNATURE:_____DATE: _____

RELATIONSHIP TO THE PATIENT: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

IT IS THE POLICY OF NORTH BAY EYE ASSOCIATES NOT TO RELEASE CONFIDENTIAL INFORMATION TO UNAUTHORIZED PEOPLE BY TELEPHONE, VOICE MESSAGES, CELL PHONE, OR E-MAIL WITHOUT THE CONSENT OF THE PATIENT.

Please list names and relationship of individuals to whom we may release medical information as well as the type of information that may be released:

NAME:	RELATIONSHIP:	☐APPOINTMENT ☐BILLING ☐ TREATMENT ☐ ALL
NAME:	RELATIONSHIP:	☐APPOINTMENT ☐BILLING ☐ TREATMENT ☐ ALL
NAME:	RELATIONSHIP:	☐APPOINTMENT ☐BILLING ☐ TREATMENT ☐ ALL

NORTH BAY EYE ASSOCIATES MEDICAL HISTORY FORM

NAME:_____ DOB:_____ SEX: ☐ M ☐ F

PREFERRED PHARMACY: _____
Name Address City State Zip Code

PRIMARY CARE PHYSICIAN: _____
Name Address City State Zip Code

OTHER SPECIALIST (e.g. Cardiologist, Endocrinologist): _____
Name Address City State Zip Code

REFERRED BY: _____
Name Address City State Zip Code

PERSONAL EYE HISTORY

	YES	NO		YES	NO
CATARACTS			MACULAR DEGENERATION		
RETINAL DETACHMENT			EYE INJURY		
STRABISMUS/LAZY EYE			CORNEAL DISEASE		
GLAUCOMA			OTHER EYE PROBLEMS? _____		

DO YOU WEAR? ☐ GLASSES ☐ CONTACTS for ☐ Distance ☐ Reading

IF CONTACTS: ☐ DAILY WEAR ☐ EXTENDED WEAR ☐ HARD ☐ SOFT ☐ GAS PERMEABLE

PERSONAL MEDICAL HISTORY

	YES	NO		YES	NO
HEART DISEASE			DIABETES		
BLOOD DISORDERS			LUNGS		
HIGH BLOOD PRESSURE			STOMACH/ BOWEL		
HIGH CHOLESTEROL			BONES/ MUSCLES		
BRAIN (TUMOR/STROKE)			SKIN (RASH/ GROWTH)		
ASTHMA			THYROID DISEASE		
CANCER			OTHER: _____		

FAMILY HISTORY HAS ANY RELATIVE HAD ANY OF THE FOLLOWING?

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
CATARACTS				ARTHRITIS			
GLAUCOMA				CANCER			
RETINAL DETACHMENT				HEART DISEASE			
MACULAR DEGENERATION				KIDNEY DISEASE			
STRABISMUS (LAZY EYE)				AUTOIMMUNE_____			
BLINDNESS				STROKE			
DIABETES				OTHER_____			

LIST ALL PREVIOUS GENERAL AND/OR EYE SURGERIES: Indicate reason and surgery date(s): ☐ None

*****Please complete the other side of this form*****

LIST ALL ALLERGIES (Include: Tape, latex, IV Dye, and Medications): ☐ Yes (list below) ☐ None Known

_____

_____

LIST ALL CURRENT EYE MEDICATIONS: (Including over-the-counter): ☐ None Taken

Name of Medication	Dosage	Frequency	Reason	Start Date

LIST ALL OTHER MEDICATIONS/NUTRITIONAL SUPPLEMENTS/HERBS/RECREATIONAL DRUGS CURRENTLY

TAKEN: (Including over-the-counter): ☐ None Taken

Name of Medication	Dosage	Frequency	Reason	Start Date

SOCIAL HISTORY

Are you or could you be pregnant at this time? ☐ YES ☐ NO Are you trying to become pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ Yes ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If yes, how often? ☐ Occasionally ☐ 1/Day ☐ 2-3/Day ☐ 4+/Day

Do you use tobacco? ☐ YES ☐ NO If yes, how often? ☐ Occasionally ☐ ½ Pack/Day ☐ 1 Pack/Day ☐ 1+Pack/Day

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history. Signature_____Date _____

RELATIONSHIP TO THE PATIENT: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

NORTH BAY EYE ASSOCIATES, INC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- ☐ Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- ☐ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- ☐ Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- ☐ The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- ☐ Most uses and disclosure of psychotherapy notes;
- ☐ Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- ☐ Disclosures that constitute a sale of PHI under HIPAA; and
- ☐ Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- ☐ The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- ☐ The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- ☐ The right to inspect and copy your PHI.
- ☐ The right to amend your PHI.
- ☐ The right to receive an accounting of disclosures of your PHI.
- ☐ The right to obtain a paper copy of this notice from us upon request.
- ☐ The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

To exercise any of your rights, please contact us in writing at **North Bay Eye Associates, Inc., Attn: Privacy Officer, 50 Professional Center Drive, Suite 210, Rohnert Park, CA 94928.**

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights (e-mail: OCRComplaint@hhs.gov) . You may also contact us at North Bay Eye Associates, Inc., Attn: Privacy Officer, 50 Professional Center Drive, Suite 201, Rohnert Park, CA 94928. We will not retaliate against you for filing a complaint.

Directions to

North Bay Eye Associates

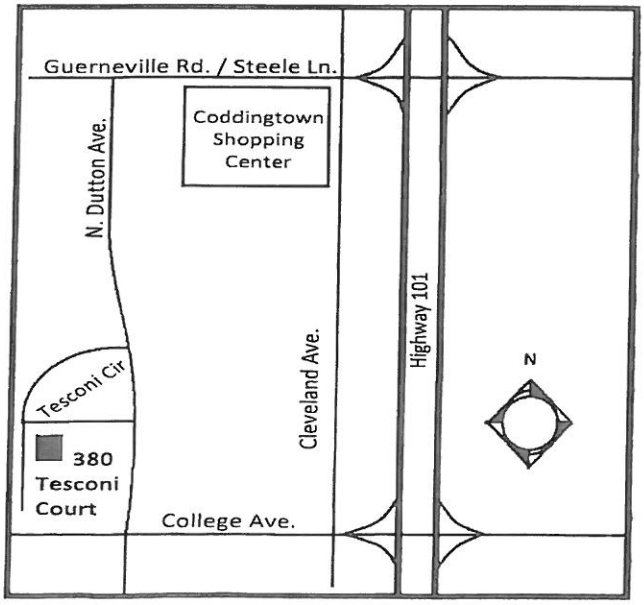
Santa Rosa & Healdsburg Office

380 Tesconi Court

Santa Rosa, CA 95401

(707) 544-3375

1. North or South on 101 to College Ave. Exit
2. West on College Ave.
3. Right on North Dutton Ave.
4. Left on Tesconi Circle
5. Go to end of street & turn left at Tesconi Ct.
6. First driveway on the left
7. Office located at 380 Tesconi Ct.

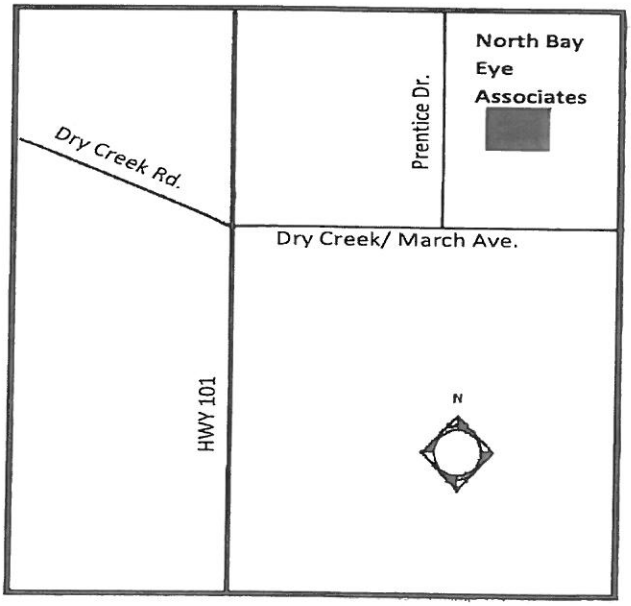


1310 Prentice Drive, Suite F

Healdsburg, CA 95448

(707) 433-9475

1. North or South on 101 to Dry Creek Exit
2. Proceed East on Dry Creek/March Ave
3. Left on Prentice Drive
4. Office located at 1310 Prentice Drive, Suite F



Directions to

North Bay Eye Associates

Sonoma & Petaluma Offices

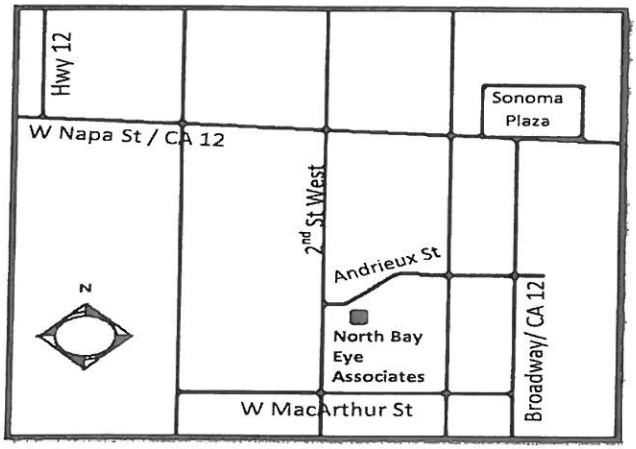
181 Andrieux Street, Suite 100 & 101

Sonoma, CA 95476

(707) 996-1052

From Santa Rosa/ N.W. Area

1. Highway 12 East
2. Right on 2nd Street West
3. Left on Andrieux Street
4. Office located at 181 Andrieux Street, Suite 100 & 101



From Petaluma/ South

1. North on Broadway/ CA 12 W
2. Left on W MacArthur St
3. Right on 2nd Street West
4. Left on Andrieux Street
5. Office located at 181 Andrieux Street, Suite 100 & 101

North Bay Eye Associates

(For Medical/ Surgical Patients)

104 Lynch Creek Way, Suites 12 & 15

(707) 762-3573

108 Lynch Creek Way, Suite 1

Petaluma, CA 94952

(707) 775-39-35

1. North or South on 101 to Washington Blvd. Exit
2. East on Washington Blvd.
3. Immediate left on McDowell
4. Left on Lynch Creek Way
5. First driveway on right