Date: _____ Referred By _____

GENERAL PERSONAL INFORMATION

Name _____
First Middle Last
Date of Birth _____ Age _____ Sex _____
SSN _____ Drivers License Number _____
Daytime Phone ( )_____ Evening Phone ( ) _____
E-Mail _____
Billing Address _____
City _____ State _____ Zip _____
Employer/Occupation _____
Primary Care Physician_____

PARENT/GUARDIAN INFORMATION

(*If patient is under the age of 18, parent/guardian information must be provided below*)
Name _____
First Middle Last
Date of Birth_____ SSN_____
Billing Address _____
City _____ State _____ Zip _____
Name _____
First Middle Last
Date of Birth_____ SSN_____
Billing Address _____
City _____ State _____ Zip _____
Dependent Child's Insurance Carrier _____
Insurance Subscriber (mother/father/legal guardian) _____

INSURANCE INFORMATION

Health Insurance: (Anthem BC, Medicare, etc.) _____
Full name of insured (First, Middle, Last) Insured's ID Number
Secondary Insurance: (If applicable) _____
Full name of insured (First, Middle, Last) Insured's ID Number
Vision Insurance: (VSP, MES, Eyemed, BlueView, etc?) _____
Full name of member (First, Middle, Last) Insured's ID Number

SPOUSAL INFORMATION

Name _____
First Middle Last
Date of Birth _____ Social Security Number _____

EMERGENCY CONTACT

Name _____
First Middle Last
Street Address _____
City _____ State _____ Zip _____
Daytime Phone ( ) _____ Evening Phone ( ) _____

A FEW OTHER QUESTIONS

What is the reason for today's visit? _____
Are you interested in learning more about COSMETIC surgery? Yes ○ No ○
How did you hear about our office? _____
Thank you for taking the time to fill out this form completely so we can better help you.
I acknowledge receipt of the *SHARMA OPHTHALMIC SERVICES* Notice of Privacy Practices:
Signature _____ Date _____

Medical History Questionnaire Date

Name Date of Birth
Date of last eye exam
List any medications you currently take (Rx and over-the-counter):
Do you have allergies to any medications? ❍YES ❍NO
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):
List any surgeries you have had (cataract, appendectomy):

YES NO Details

EYES (poor vision, eye pain, tearing, redness, etc.) ❍ ❍
GENERAL / CONSTITUTIONAL ❍ ❍
(fever, heat stroke, weight loss, weight gain, unusually tired)
EARS, NOSE, THROAT ❍ ❍
(hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)
CARDIOVASCULAR (high BP, racing pulse, etc.) ❍ ❍
RESPIRATORY (congestion, wheezing, short of breath, etc.) ❍ ❍
GASTROINTESTINAL ❍ ❍
(stomach upset, diarrhea, constipation, hernia, ulcers, etc.
GENITAL, KIDNEY, BLADDER ❍ ❍
(painful urination, frequent urination, impotence, yellow jaundice, etc.)
FEMALES Are you pregnant? Nursing? ❍ ❍
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, ❍ ❍
cramps, arthritis, etc.)
SKIN (pimples, warts, growths, rash, etc.) ❍ ❍
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.) ❍ ❍
PSYCHIATRIC (anxiety, depression, insomnia) ❍ ❍
ENDOCRINE (diabetes, hypothyroid, etc.) ❍ ❍
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems ❍ ❍
related to blood transfusion, etc.)
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, ❍ ❍
itching, hives, lupus, etc.)
FAMILY HISTORY (Mother, Father, Grandparent, Sibling) ❍YES ❍NO ❍UNKNOWN
Has any member of your family had these diseases (circle all that apply)? Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:
SOCIAL HISTORY Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ❍YES ❍NO
Have you ever had a blood transfusion? ❍YES ❍NO • Do you drink alcohol? ❍YES ❍NO If YES, how much?
Do you smoke? ❍YES ❍NO If YES, how much? How many years?
Physician’s Signature Date

San Benito County EyeCare

Lifetime Authorization of Insurance Benefits and Billing Information for All Patients

Welcome to the office of Nazhat Parveen Sharma MD.. Due to the fact that insurance companies frequently change their carriers, plans and benefits, it is difficult for this office to verify that your insurance carrier is one that our physician is contracted with at the time of your visit. We do attempt to confirm your insurance coverage, but it is not always possible to ascertain this information accurately at the time of your visit. You are encouraged to verify your benefits and whether Dr. Sharma is contracted providers *prior* to your office visit. Please be aware that we will bill your insurance as a service to you. It is your responsibility to be up to date on your insurance policy and its requirements, covered physicians, covered services, deductibles, and co-payment amounts. Regardless of your insurance coverage, you will have the opportunity to be seen by our doctors as we do not want to withhold services inappropriately. When you check in at the front desk, we will as to make a copy of your insurance card for our records. *Making a copy of your insurance card does not confirm that you will have coverage with our office*.
Some medical insurance plans do cover an annual eye exam; however, some of these plans exclude all refractive services from their coverage. The fee for refractive services, which will be performed as a portion of our eye exam, is $65.00. *By signing this form, I agree to be personally and fully responsible for the refractive portion of my exam* _____ (initials).
It is your responsibility to know whether Dr. Sharma is a contracted provider for you insurance company. If we provide a service to you and we ARE NOT *a contracted provider, your insurance company will notify us that you are liable for either all or a large portion of the fee for your visit.*
By signing below, I request that payment of insurance benefits be made on my behalf to Dr. Nazhat P Sharma. for any services provided to me by the physicians/suppliers of this facility. I understand that me signature requests that payment be made and authorizes the release of any medical information necessary to ensure payment.
MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made to Dr. Nazhat P Sharma for any services provided me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I further understand that Dr. Sharma. has agreed to accept the allowed charge determined by Medicare as the full charge. Medicare pays 80% of that charge and I understand that I am responsible for the balance of the charge, deductibles, coinsurance and non-covered services. Coinsurance and deductibles are determined by the insurance carrier.
I understand that Medicare excludes all refractive services *from their coverage. I agree to be personally and fully responsible for the refractive portion of my exam* _____ (initials). Medicare (and most other insurance) does not cover eyeglasses or medications in most cases. If other health insurance coverage is indicated (secondary insurance) my signature authorizes the release of necessary information to that insurer or agency.
HMO/PRIOR AUTHORIZATION PATIENTS: I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Dr. Sharma. If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including co-payments and deductibles.
PRIVATE PAY PATIENTS-*Payment for services rendered is expected at the time of service*. We offer a 10% discount for your cooperation and prompt payment on medical services. If at anytime in the future, you become insured with medical or vision coverage, please let our staff know and we will be more than happy to bill for you. We are committed to providing quality service. With the changes in the health care arena, this can be a time consuming process. We thank you in advance for your cooperation and patience.
I have read the above information. I understand that all charges for services rendered are ultimately my responsibility. Should NAzhat P Sharma MD not be a contracted provider, or if the services rendered are not a covered benefit under my plan, I am responsible for all charges related to the services provided for me and will pay in full for such charges.

Patient (Responsible Party) Signature Date

A copy of this form will be provided for you at your request.

San Benito County EyeCare

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

Why am I receiving this Notice? We are required by law to maintain the privacy of your health information. We are required to inform you of our legal duties and privacy practices where your protected health information is concerned.

This notice contains a summary of our health information privacy practices and of your rights relating to your health information. In the absence of an express statement to the contrary, this notice is not intended to preclude or restrict uses or disclosures of health information that are otherwise permitted by law, or to give you rights that we are not required by law to give you.

We are required to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice, and to make the new notice effective for all health information we maintain. If we make material changes to this notice, you will be provided an updated copy at your next office visit

How do we use and disclose my health information? We maintain health-related records about you, including medical records and billing and payment information. We use this information and disclose it to others for the following purposes:

Treatment. We use your health information to provide health care to you and to coordinate your health care with other providers, and we disclose it to other health care providers to enable them to provide health care services to you. For example, if we refer you to a specialist physician we send all or a part of your health record to the specialist to assist him or her in evaluating and treating you.

Payment. We use and disclose your health information to obtain payment for health care services we provide to you, including determining your eligibility for benefits. For example, we may send a claim to your insurer that contains information about the services we provided to you, or we may send a bill to a family member who is responsible for paying for your care.

Health care operations. We use and disclose your health information as necessary to enable us to operate our medical practice. For example, we use our patients' claims information for our internal financial accounting activities, and we review health records to ensure quality.

We also disclose health information to our contractors and agents who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures for payment or operational purposes. For example, companies that provide or maintain our computer systems may have access to computerized health information in the course of providing services to us.

Contacting you. We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care. Unless you object, we may disclose medical information to a friend or family member who is involved in your care, to the extent we judge necessary for their participation.

Other Disclosures. We may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Here are the general kinds of disclosures we may be required or allowed to make without your authorization:

• Disclosures that are required by state or federal law.
• Disclosures to public health authorities or to other persons in connection with public health activities.
• Disclosures to government agencies authorized to receive reports of abuse or neglect of children or dependent adults, or domestic violence.

• Disclosures to agencies responsible for overseeing the health care system, for audits, inspections or investigations.
• Disclosures for judicial and administrative proceedings, such as lawsuits.
• Disclosures to law enforcement agencies.
• Disclosures to coroners and medical examiners.
• Disclosures to organ procurement agencies, if you are an organ donor or a possible donor.
• Disclosures to researchers conducting research under the auspices of an Institutional Review Board or privacy board.
• Disclosures to avert a serious threat to health or safety.
• If you are a member of the armed forces or a veteran, we may release health information to your military command authority or to the veterans' administration to assist in determining your eligibility for veterans' benefits.
• Disclosures to assist authorized federal officials in national security activities, or for the provision of protective
services to officials.
• If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release
health information about you to the institution or official.
• Disclosures to other agencies administering government health benefit programs, as authorized or required by law.
• Disclosures to comply with workers' compensation laws.

Limitations. In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of health information for purposes unrelated to the program. In addition, there are special restrictions on the disclosure
of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Authorization. Except as described above, we will not permit other uses and disclosures of your health information without your written authorization, which you may revoke at any time in the manner described in our authorization form.

Patient's Rights

What rights do I have as a patient of the practice? As a patient of the practice you have the following rights:

• You have the right to ask us to restrict certain uses and disclosures of your health information. However, we are not required to agree to any restrictions requested by our patients.

• You have the right to receive confidential communications from us, for example by asking us to contact you at a particular telephone number, post office box or other address.

• You have the right to see and copy any certain records that we maintain. These include our medical records and billing records concerning you. Under certain circumstances, we may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.

• If you feel the information in our records is wrong, you have the right to request us to amend the records. We may deny your request in certain circumstances. If your request is denied, you have the right to submit a statement for inclusion in the record.

• You have the right to receive a report of non-routine disclosures that we have made of your health information, up to six years prior from the date of your request (but not earlier than January 2007). There are some exceptions: for example, we do not maintain records of disclosures made with your authorization; disclosures made for the purposes of treatment, obtaining payment for health services, or operating our medical practice; disclosures made to you; and certain other disclosures.

• If you received this notice electronically, you have the right to request a paper copy from us at any time.

The foregoing is a general statement of your rights. They are subject to all limitations permitted or required by law.

How do I exercise these rights? You can exercise any of your rights by sending a written request to our Privacy Official at the address below.

How do I file a complaint if my privacy rights are violated? You have the right to file a complaint with our Privacy Official if you believe your privacy rights have been violated. You must provide us with specific, written information to support your complaint. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Contact the Secretary of Health and Human Services at:

Secretary of Health and Human Services, Office for Civil Rights • 50 United Nations Plaza, Room 322

San Francisco, CA 94102