DEMOGRAPHICS QUESTIONNAIRE

Name ____ Date ____________________
(Last) (First) (MI)

Birth Date ____________________ Age ______ Social Security Number ____________________

Marital Status (circle): married / single / divorced / widowed Gender: M / F

Address ______________________________ City ____________ State __________ Zip Code ________

E-mail Address ____________________________ Fax Number ____________________________

Home Phone __________________________ Work Phone __________________________ Ext ________

Mobile Phone __________________________ Other Contact Phone __________________________

Name of Other Contact and Relationship to you: ______________________________________

Occupation (current or former) ____

Retired: ______ YES ______ NO Employer ______________________________________

Activities / Hobbies ____

Primary Insurance ____________________________ ID# ____________________________

Secondary Insurance __________________________ ID# ____________________________

What are your concerns or reason for referral? ______________________________________

____

How were you referred? ____

Your primary care physician ______________________________________ Phone ______________

Your general eye doctor ____ Phone ______________

MEDICAL HISTORY QUESTIONNAIRE

List any **medications** you currently take (prescription and over-the-counter): ______________________

____

____

____

____

Do you take **prostate medicine** to help with urination?
Circle: NONE FLOMAX UROXATRAL HYTRIN CARDURA SAWPALMETTO

Do you have **ALLERGIES** to any medications? **YES NO** **Latex Allergy? YES NO**

If YES, list the medications: ______________________

List any **eye surgeries** you have had, with year and month if known (cataract, LASIK, RK, PRK, etc.): __________

____

____

____

List any **general surgeries** you have had, with year and month if known (appendectomy, heart bypass, etc.):

____

____

MEDICAL HISTORY **P** = PATIENT (YOU) (Example: If you and your father have Glaucoma, mark "P F" under
M=mother **F**=father **S**=sibling **GP**=grandparent "YES" in the Glaucoma row.)

DISEASE	**YES**	**Details**
Blindness		
Glaucoma		
Macular Degeneration		
Arthritis		
Cancer		
Diabetes		
Heart disease or high blood pressure		
Lung disease (asthma, COPD, etc.)		
Lupus		
Stroke		
Thyroid disease		
Other		
Other		
Other		

REVIEW OF SYSTEMS

Do you *currently* have any problems in the following areas? If YES, please provide information.

	YES	NO	Details
EYES			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

SOCIAL HISTORY

Have you ever had a blood transfusion?............YES NO

Do you drink alcohol?............YES NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke?....................YES NO If YES: occasional ½ pack/day 1 pack/day 1+pack/day

*Physician's Signature*____ *Date*_________________________

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(print)* | Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to __Barry S. Seibel MD., for services furnished me by __Barry S. Seibel M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Barry S. Seibel MD accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Barry S. Seibel MD., if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Barry S. Seibel MD Inc. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Barry S. Seibel MD for reimbursement for services rendered, and (2) any health care provider for continued patient care. Barry S. Seibel MD may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Barry S. Seibel MD maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Barry S. Seibel MD has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Barry S. Seibel MD if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Barry S. Seibel MD contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Barry S. Seibel MD to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Barry S. Seibel MD I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Barry S. Seibel MD for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Barry S. Seibel MD. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Barry S. Seibel MD. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party | Date

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Private Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law, to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcements officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers' Compensation and similar programs.

Your rights regarding your health

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may prefer Email, your cell phone or your home phone. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right that we restrict our disclosure of your health information to only certain 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.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Barry S. Seibel, M.D., (310) 444-1134, 11620 Wilshire Blvd, Suite 711, Los Angeles, CA, 90025.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Barry S. Seibel, M.D.- 11620 Wilshire Blvd., Suite 711, Los Angeles, CA. 90025. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. 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 Health and Human Services. To file a complaint with our practice, contact Barry S. Seibel, M.D., (310) 444-1134. All complaints must be submitted in writing (see address in 4 above). You will not be penalized for filing a complaint.

7. 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.

If you have any questions regarding this notice or our health information privacy policies, please contact Barry S. Seibel, M.D., (310) 444-1134.

I agree that Seibel Vision may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I hereby acknowledge that I have been presented with a copy of Barry S. Seibel, M.D., Notice of Privacy Practices.

Signature ______________________________

Date ______________________________

Name of Patient ______________________________