REGISTRATION FORM / FORMA DE REGISTRO

In the case that a question does not pertain to you, please answer with "not applicable" (N/A)

En caso de que una pregunta no aplique, por favor responda "no aplica" (N/A)

Today's Date / *Fecha*: _____

PATIENT INFORMATION / INFORMACION DEL PACIENTE

Last Name / *Apellido del Paciente*:		First Name / *Nombre*:
Birth Date / *Fecha de Nacimiento* (MM/DD/YYYY)	Age / *Edad*:	Social Security # / # *de Seguro Social*:
Home Phone / *Tel. de Casa*:	Work Phone / *Tel. de Trabajo*	Cell Phone / *Tel. Cellular:*
E-mail / *Correo Electronico*:	☐ Male / *Masculino* ☐ Female / *Femenino* ☐ Non-binary	
Mailing Address / *Direccion Postal*:		Apartment / *Apartamento:*
City / *Ciudad*:	State / *Estado*:	Zip Code / *Codigo Postal*:
Occupation / *Ocupacion*:	Employer / *Empleador*:	
Marital Status / *Estado Civil*:	Primary Language / *Idioma Principal*:	

Race / Raza:

☐ Black/African American (Afroamericano) ☐ Native American (*Nativo Americano*)

☐ Asian (*Asiatico*) ☐ Pacific Islander (*Origen de las Islas del Pacifico*)

☐ Caucasian (*Caucasico*) ☐ Decline to Answer (*Me niego a contestar*)

☐ Hispanic, Latino, or Spanish origin (*Hispano, Latino, or o de origen Español*)

Parent/Guardian Name (*Nombre del Padre/Guardian*)	Parent/Guardian Phone (*Tel. del Padre/Guardian*)
Parent/Guardian Name (Nombre del Padre/Guardian)	Parent/Guardian Phone (*Tel. del Padre/Guardian*)

How did you hear about us? *¿Como fue informado acerca de nosotros*?

☐ Friend / *Amigo(a)* ☐ Internet / Pagina Web ☐ Phonebook / *Directorio Telefonicio* ☐ Other/ *Otro*

INFORMATION OF RESPONSIBLE PARTY / INFORMACION DE LA PERSONA RESPONSIBLE

Last Name / *Apellido del Paciente*:	First Name / *Nombre*:
Address / *Direccion*:	Phone Number / *Tel*:
	Relationship to Patient / *Relacion al Paciente*:
Birth Date / *Fecha de Nacimiento* (MM/DD/YYYY)	
Employer / *Empleador*:	Employer Phone # / *Tel. Del Empleador*:
Employer Address / *Direccion del Empleador*:	

IN CASE OF EMERGENCY / EN CASO DE EMERGENCIA

Name / *Nombre*:	Relationship to Patient / *Relacion al Paciente*:
Phone # / *Tel*:	Cell Phone / *Tel. Cellular*:

The above information is true to the best of my knowledge. I authorize Medicare or my insurance company to pay the Eye Institute of Marin and my physician directly. I understand that I am financially responsible for any balance. I also authorize the Eye Institute of Marin or insurance company to release any information required to process my claims.

La informacion anterior es verdadera segun mi entender. Autorizo a Medicare o a mi compañia de seguros a pagar a Eye Institute of Marin mi medico directamente. Entiendo que soy responsable financieramente por cualquier cuentas pendientes. Tambien autorizo a Eye Institute of Marin o a mi compañia de seguros a proveer cualquier informacion que se requiera para procesar mis pagos.

Patient/Parent/Guardian Signature (*Firma del Paciente/Guardian*) **Date / Fecha:**

X

Name: _____Date: _____

My Primary Care Doctor is: _____

I was referred by_____ for _____

My last eye exam was _____ I wear: ☐ Glasses ☐ Contact Lenses ☐ None

Pharmacy & Location: _____

Smoking status: ☐ Current smoker, packs/day: ☐ Never smoker ☐ Former smoker, quit:
I take ☐ **Eye Drops** ☐ **Flomax** ☐ **Blood thinners** ☐ **STEROIDS** (oral/nasal spray /inhalers)

List Medications: ☐ No medications			Medication Allergies: None ☐	Reaction

Medical History

Eyes:	☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Retinal Detachment ☐ Flashes ☐ Floaters		Other:	
Cardiac:	☐ Chest pain ☐ High blood pressure ☐ Stroke ☐ High Cholesterol ☐ Arrhythmia ☐ Heart attack		Other:	
Psychiatric/ Neurologic	☐ Depression ☐ Anxiety ☐ Seizures ☐ Memory loss		Other:	
Skin	☐ Eczema ☐ Psoriasis ☐ Rosacea		Other:	
Pulmonary	☐ Asthma ☐ Emphysema/COPD		Other:	
Systemic	☐ Hypothyroidism ☐ Hyperthyroidism ☐Autoimmune disease: _____		Other:	
Diabetes	Type I or II ☐ Insulin dependent	Blood sugar: Last HgA1C:	☐ Controlled ☐ Uncontrolled	Year Diagnosed:

Other Health Conditions:

Past Surgeries (please include non-eye related):

I have a **family history** of (Please include both eye related and non-eye related): ☐ None / Not sure:

COVID-19 Vaccination: ☐ YES ☐ NO Date: _____

Pneumonia Vaccination: ☐ YES ☐ NO Date: _____

Do you have a healthcare Proxy set up in case you are unable to make your own healthcare decisions? ☐ YES ☐ NO
Name/Phone number: _____

Reviewed by:_____Date: _____

Eye Institute of Marin Kathryn Najafi-Tagol, M.D.
10 Paul Drive, San Rafael, CA 94903
Ph 415-444-0300 Fax 415-444-0301

Kathryn Najafi-Tagol, MD
10 Paul Drive
San Rafael,CA 94903
(415) 444-0300

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing the Eye Institute of Marin for your medical needs. We are committed to providing you with the highest quality healthcare. We ask you to read and sign this form to acknowledge your understanding of our patient financial policies.

The patient (or patient's guardian, if a minor) is ultimately responsible for payment of treatment and care.

As a courtesy, we will bill your insurance for you. However, you are responsible for knowing your insurance coverage and to provide the most correct and updated information regarding insurance.

Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan(s). Copays are due at the time of service.

Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.

Patients may incur and are responsible for payment of additional charges, if applicable. These charges may include a charge for returned checks $25.00.

Private pay patients are responsible for all examination/procedure charges incurred. Payment is required at the time of service.

If surgery is canceled within 72 business hours of your scheduled procedure patient will incur a $250 cancellation fee.

If office procedures are canceled within 72 business hours of your scheduled procedure patient will incur a $150 cancellation fee.

Our office policy requires at least a 48 business hour notice if you need to cancel or reschedule your appointment. If we are not notified before the 48 business hours you will incur a $75.00 cancellation fee.

Refraction is the process of determining if there is a need for prescription glasses. It is an essential part of an eye examination and necessary in order to release a prescription. **This is considered a non-covered procedure by most medical insurance companies. If this procedure is not covered, you will be responsible for a procedure fee of $95.** Fitting of contact lenses is also considered a non-covered procedure and you will be responsible for a fitting fee, which does not include the contact lenses themselves. The fee will vary depending on the type of contact lenses being fit.

Patient Acknowledgment
By my signature below, I hereby authorize assignment of financial benefits directly to Eye Institute of Marin and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand I am financially responsible for charges not covered by this assignment.

Signature of Responsible Party Date

Kathryn Najafi-Tagol, MD
10 Paul Drive
San Rafael, CA 94903
(415) 444-0300

Consent to Obtain Medication History

The Eye Institute of Marin utilizes an electronic medical record system to ensure the highest quality of care possible for you and your vision. This system allows the collection and review of your medication history. This medication history is a list of prescribed medications from our doctors as well as any other doctors who might have given you a prescription. **Obtaining both an accurate and up-to-date medication history is important for our doctors to provide effective treatments and to avoid potentially dangerous interactions between prescribed medications.**

This list can come from a variety of sources including your pharmacy and your healthcare insurer. While this medication history is a useful guide for our doctors, some medications may still be missing from the list. Some pharmacies may not make medication history available to us. Medications purchased without medical insurance will not be listed. Over-the-counter medications, supplements, and herbal medications also are missing from the list. It is important to disclose this information with our staff to help ensure your safety and highest possible quality of care.

By signing this consent form you give us permission to collect your medication history, for your pharmacy and health insurance plan to disclose your prescription information with us. That includes prescription medications to treat HIV/AIDS and mental health conditions. This will become part of your health record with our office.

I hereby give my permission for the Eye Institute of Marin to obtain my medication history from my pharmacy, my health insurance plans, and my other healthcare providers.

_____

Patient Signature Date of Birth

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist/optometrist to better examine the small structures inside of your eyes.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination it's best if you make arrangements not to drive yourself. If you do not have sunglasses with you, please ask our staff for a disposable pair.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Dr. Najafi-Tagol, and/or such assistants as may be designated by her, to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Acknowledgement

_____

_ Patient Signature Date

RECORDS RELEASE AUTHORIZATION

TO☐/FROM☐
Kathryn Najafi-Tagol, MD
Eye Institute of Marin

10 Paul Drive
San Rafael, CA 94903

Ph: (415) 444-0300
Fax: (415) 444-0301

TO☐/FROM☐
Name: _____
_____

Address: _____
_____
_____

Ph:_____
Fax:_____

I consent to release the following health information (check all that applies):

Date(s) of treatment:_____

☐ All health care information

☐ Health care information relating to the following treatment or condition:

The following information will not be released unless the specific item is checked:

☐ information pertaining to drug & alcohol abuse, diagnosis or treatment

☐ information pertaining to mental health diagnosis or treatment

☐ HIV/AIDS test results

☐ information pertaining to genetic testing

This authorization shall in force and effect until _____ (date or event), at which time this authorization expires.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand I have the right to receive a copy of this authorization upon request.
I understand I have a right to request restrictions on the uses and disclosures of health information; however, Eye Institute of Marin/Dr. Najafi-Tagol, it's employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____

Patient Name (Print) Date

_____

_ Patient Signature Date of Birth

Authorized by Dr. Kathryn Najafi-Tagol

10 Paul Drive
San Rafael, CA 94903
(415) 444-0300

PRIVACY ACKNOWLEDGEMENT AND GENERAL CONSENT

I understand my privacy is protected and I have read the Notice of Privacy Practices.		☐ Yes
I consent to receive medical care and treatment from Eye Institute of Marin.		☐ Yes
I have read and understand the Office and Financial Policies. I understand any violation of these terms is subject to referral to a collection agency and/or immediate dismissal.		☐ Yes
I give my physician and/or my physician representative permission to leave a confidential message for me at the following **phone number**: ( ) -		☐ Yes
I give my physician and/or my physician representative permission to discuss by medical care with:	Name/Relationship:	Phone:

I understand under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain right to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge I have read/received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time in writing to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____

Patient Name (Print) Date

_____

Patient Signature Relationship to Patient (if applicable) Date of Birth

For office use only:
I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Signature:_____ Privacy Acknowledgement and General Consent

Reason:_____

CREDIT CARD AUTHORIZATION FORM

We require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance company does not cover, but for which you are liable.

Your credit card information is kept confidential and electronically secure by our Merchant Services. Charges to your credit card are made only after the claim has been filed and processed by your insurer and the insurance portion of the claim has been paid, adjusted, and posted to your account.

I, the undersigned, authorize Eye Institute of Marin to charge the portion of my bill that is my financial responsibility as per the insurance company EOB to the following credit card. Balances of $50 or less will be charged immediately, otherwise I will receive a statement from Eye Institute of Marin for the balance my insurance company determines I owe. A "no-show" fee of $75 for not cancelling or rescheduling my appointment 48 hours prior to the appointment time, will be automatically charged to my credit card. I understand that my credit card will be charged 10 days after the date of statement if other arrangements have not been made.

I agree to notify and update my credit card information as necessary. A fee of $35 will be added to my account if my credit card is denied.

This authorization will remain in effect until I cancel it with a 60-day notification in writing. The account must be in good standing.

Patient Name:	
Credit Card Billing Address:	
Cardholder's Name:	
Credit Card Type	Visa ☐ Master Card ☐ AMEX ☐
Credit Card #:	
Exp. Date:	Security Code:

Patient Signature:_____Date:_____

Eye Institute of Marin, Kathryn Najafi-Tagol M.D.
10 Paul Drive, San Rafael CA 94903
Tel: 415-444-0300 Fax: 415-444-0301 www.eyeinstituteofmarin.com

A. Notifier: Eye Institute Of Marin
10 Paul Drive San Rafael 94903
Phone: (415) 444-0300 Fax: (415)444-0301
Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

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

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

D. Diagnostic Testing	E. Reason Medicare May Not Pay:	F. Estimated Out of Pocket Cost:
1. Corneal Topography Images 92025 2. Fundus Imaging 92250 3. Pachymetry 76514 4. Meibography Scan 92285 5. Ophthalmic Biometry (IOLM) 92136 6. Gonioscopy 92020 7. OCT RNFL 92133 8. OCT MAC 92134 9. Visual Field Exam 92083 10. Refraction 92015 11. External Photos 92285	Medicare will only pay for standard examinations, testing, followup care that if deamed medically necessary. Medicare may deny the medical service/ procedure if "not medically necessary," there were "too many or too frequent" services or treatments, or due to a local coverage determination, thus making them the patient's financial responsibility.	92025 $92.44 92250 $94.24 76514 $27.68 92285 $62.06 92136 $118.48 92020 $68.44 92133 $92.38 92134 $101.64 92083 $162.10 92015 $95.00

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 D listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare 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 D listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

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

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

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Physician & Surgeon
Kathryn Najafi-Tagol, M.D.
Ph. (415) 444-0300
Fax (415) 444-0301

Eye Institute of MARIN

10 Paul Drive
San Rafael, CA 94903

Patient's Name: _____ **ID #:**_____

NOTICE OF EXCLUSIONS FROM HEALTH PLAN BENEFITS (NEHB)
There are items and services for which your health plan may not pay.

1. Your health plan does **not** pay for all your health care costs. The health plan only pays for covered benefits. Some items are not covered benefits and your insurance will not pay for them.
2. When you receive an item or service that is not a covered benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services or not. **Before you decide, you should read this entire notice carefully.**

o If you do not understand why your insurance will not pay, ask us to explain.

Ophthalmic diagnostics that may not be covered with insurance:
(not including co-payments, deductibles, or co-insurances associated with your insurance plan)

1.	**Corneal Topography Images 92025**	**$92.44**
2.	**Fundus Imaging 92250**	**$94.24**
3.	**Pachymetry 76514**	**$27.68**
4.	**Meibography Scan 92285**	**$62.06**
5.	**Ophthalmic Biometry (IOLM) 92136**	**$118.48**
6.	**Gonioscopy 92020**	**$68.44**
7.	**OCT RNFL 92133**	**$92.38**
8.	**OCT MAC 92134**	**$101.64**
9.	**Visual Field Exam 92083**	**$162.10**
10.	**Refraction 92015**	**$95.00**
11.	**External Photos**	**$62.06**

By signing below, I acknowledge I am aware of non-covered service(s) and agree to pay for any additional charges determined by my medical insurance(s) policy plan such as; co-payments, co-insurance, deductibles etc.

_____ _____

Signature of patient or person acting on patient's behalf **Date**