MACULA RETINA VITREOUS CENTER
SURGICAL AND MEDICAL RETINA

TORRANCE 20528 HAWTHORNE BLVD,
SUITE #201, CA 90503
P: (424) 247-9090 | F: (424) 247-9095

LOS ANGELES 1414 S. GRAND AVE,
SUITE #440, CA 90015
P: (213) 747-9090

MR #:_____

NEW PATIENT INFORMATION

PLEASE PROVIDE INFORMATION ABOUT YOUR REFERRAL:

□ Referring Doctor (reports will be sent to this doctor):_____Phone number: _____

□Friend/Family:_____□Internet Search □ Other (specify): _____

REASON FOR TODAY'S VISIT: _____

PATIENT DEMOGRAPHICS

Name:_____Date of Birth:_____DMale DFemale
LAST FIRST MI

Social Security #: ---------- _____ E-Mail Address: _____

Address: _____
STREET CITY STATE ZIP

Home #:_____Cell #:_____Work #: _____

If patient is under 18, name of responsible party: _____

Occupation:_____Employer: _____

EMERGENCY CONTACT

Name:_____Relationship: _____

Home #:_____Work #:_____Cell #: _____

PATIENT DEMOGRAPHIC:

This information is requested per Government guidelines. It is ok to decline.

Language: □English □Other: _____

Race: □African/African American □Asian/Asian American □*Decline*
□Caucasian/European American □Native American/Native Alaskan
□Native Hawaiian/Other Pacific Islander □Other

Ethnicity: □Hispanic □Non-Hispanic □*Decline*

INSURANCE INFORMATION

PRIMARY INSURANCE		*SECONDARY INSURANCE*	
□Medicare	□United Health Care	□Medicare	□United Health Care
□Anthem Blue Cross	□Cigna	□Anthem Blue Cross	□Cigna
□Blue Shield	□Aetna	□Blue Shield	□Aetna
□Other:		□Other:	□AARP

Authorization to Release & Assignment of Insurance Benefits

I UNDERSTAND THAT ANY MEDICAL CARE I RECEIVE WILL BE BILLED TO MY HEALTH INSURANCE COMPANY. IT IS MY RESPONSIBILITY TO PROVIDE A COPY OF MY INSURANCE CARD AND CORRECT DATE OF BIRTH TO MEHRAN TABAN, MD FOR THIS PURPOSE. I AUTHORIZE THE MEHRAN TABAN, MD TO FURNISH MY INSURANCE COMPANY WITH ALL INFORMATION THAT THEY MAY REQUEST REGARDING MY MEDICAL TREATMENT.

I ASSIGN TO MEHRAN TABAN, MD ALL INSURANCE PAYMENTS RELATIVE TO THE CLAIMS SUBMITTED BY MEHRAN TABAN, MD. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY OFFICE VISIT CO-PAY, IF ANY, AND FOR MY DEDUCTIBLE AND MY CO-INSURANCE, IF ANY, ONCE MY CLAIM(S) ARE PROCESSED. I UNDERSTAND THAT IF MY INSURANCE DENIES MY CLAIM(S), OR IF I HAVE NO INSURANCE, I AM PERSONALLY FINANCIALLY RESPONSIBLE FOR MY MEDICAL CARE.

_____ _____
Patient Signature (or person authorized to sign for patient) **Date**

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PRIVACY NOTICE/ HIPAA REGULATIONS

*Our office is in full compliance with the **Health Insurance Portability and Accountability Act (HIPAA).***
*A full description of the **HIPAA Regulations** is available at all times at our Front Desk. This notice describes how we may use and disclose your protected health information 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 in some cases. Protected health information means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.*

I hereby acknowledge that this Notice in its entirety is available and may be requested by me at any time prior to or during the course of my care. I may request a copy in person or request that a copy be sent to me via mail, email or fax.

_____ _____
Patient Signature (or person authorized to sign for patient) **Date**

Please list those people with whom we may discuss your personal healthcare information (doctors, family members, friends, personal assistants, nurses, etc.)

Name:_____Relationship:_____Phone #: _____

Name:_____Relationship:_____Phone #: _____

MY PHARMACIES & PHYSICIANS (names and cities)

Pharmacy:_____Phone #: _____

Primary Care:_____Phone #: _____

Other Physicians/Specialties:

Name:_____Phone #:_____Specialty:_____

Name:_____Phone #:_____Specialty: _____

MY ALLERGIES (please list all allergies)

□No Known Drug Allergies □Penicillin □Vicodin □Adhesive □Iodine □Latex

MY MEDICATIONS	**SYSTEMIC MEDICATIONS**	**DOSAGE**	**FREQUENCY**
□No Current Medications			
□See List Provided			
	EYE MEDICATIONS	**DOSAGE**	**FREQUENCY**

MY PREVIOUS SURGERIES (including Eye Surgeries)

SOCIAL HISTORY:

Do you currently smoke? DNo DYes (If yes: #_____packs per day/week) **Have you ever smoked?** DNo DYes
Do you currently drink? DNo DYes (If yes: #_____glasses per day/week)

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Patient's Name_____ **Date** _____

REVIEW OF SYSTEMS

PAST MEDICAL HISTORY: *Circle all that apply.*

Family Medical History: diabetes, hypertension

Past Medical History: diabetes, hypertension, asthma, headache, other

- **If Diabetic?** Have you had a dilated eye exam to screen for Diabetic Retinopathy? DNo DYes

OCULAR HISTORY: *Circle all that apply.*

Family Eye History: glaucoma, retinal detachment, strabismus, blindness, macular degeneration

Past Eye History: glaucoma, amblyopia, double vision, flashes, floaters, lost vision episodes, halos, pain, stinging, burning, dryness, itching, sandy feeling, tearing, trouble reading, blurred vision

- **If Glaucoma/Glaucoma Suspect?** Do you have a doctor monitoring your Glaucoma Risk? DNo DYes

SYMPTOMS

Have you recently experienced any of the following?

Constitutional		
Weight Loss	Y	N
Fever	Y	N
Night Sweats	Y	N
Ear/Nose/Throat		
Hearing Loss	Y	N
Ringing in Ears	Y	N
Chronic Sore Throat	Y	N
Bloody Nose	Y	N
Cardiovascular		
Palpitations	Y	N
Chest Pain	Y	N
Respiratory		
Chronic Cough	Y	N
Bloody Sputum	Y	N
Shortness of breath	Y	N

Gastrointestinal		
Diarrhea	Y	N
Constipation	Y	N
Bloody Stools	Y	N
Incontinence	Y	N
Neurological		
Headaches	Y	N
Numbness or Arms/Legs	Y	N
Weakness of Arms/Legs	Y	N
Dizziness	Y	N
Musculoskeletal		
Joint Pain	Y	N
Muscle Pain	Y	N
Skin		
Rashes	Y	N
Easy Bruising	Y	N

Urinary		
Frequent Urination	Y	N
Blood in Urine	Y	N
Pain with Urine	Y	N
Allergic		
Swelling of Fingers/Toes	Y	N
Redness/Scaling	Y	N
Hematologic		
Unexplained Bleeding	Y	N
Bleeding of Gums	Y	N
Eyes		
Double Vision	Y	N
Dry Eyes	Y	N
Redness	Y	N
Pain/Burning	Y	N
Tearing	Y	N

_____ _____

Patient Signature (or person authorized to sign for patient **Date**

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PHYSICIANS - PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's parties, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement not supplant, any other applicable statutory of common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____

Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TO COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By:_____
Print patient's Name

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Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. Please initial below that you have read and understand the financial policy of our office.

_____We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provideus with themost correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.

_____Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

_____**I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. If my insurance has not paid my claim within 60 days from the date insurance was billed, I will be responsible for payment. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance. If your account is sent to collections, there is a possibility that you may be discharged from the practice.**

_____I also understand that if I write a check that is returned for any reason, I will be charged a fee.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

A copy of this agreement may be used in place of the original

_____ _____
Patient or Responsible Party Signature Date

_____
Patient Printed Name

_____
Responsible Party Printed Name