SINCHAI EYE CENTER

OAT SINCHAI, M.D.
Board-Certified Ophthalmologist
Cataract & Glaucoma Specialist

RHEELA KIM, O.D.
Optometrist

WELCOME TO OUR PRACTICE
(IMPORTANT – PLEASE READ!)

Dear Patient:

We look forward to providing you with the highest level of eye care. In order to minimize your wait time and treat you as effectively as possible, **you are REQUIRED to complete and submit the following forms at least 1 WEEK PRIOR to your scheduled appointment:**

- PATIENT INFORMATION FORM
- PATIENT RESPONSIBILITY FORM
- PATIENT HEALTH HISTORY FORM
- PHYSICIAN-PATIENT ARBITRATION AGREEMENT **(A SIGNATURE IS REQUIRED)**
- PATIENT PRIVACY FORM
- MEDICAL RECORDS RELEASE FORM
- PRIVACY OF PERSONAL HEALTH INFORMATION FORM
- APPOINTMENT CANCELLATION & NO-SHOW POLICY

Please bring your **insurance card(s)** and **ID card/driver's license** with you on the day of your visit. Please also bring your current eyeglasses and/or contact lens prescriptions, and any eye drops you are currently using.

Your initial visit should take about 1 to 1½ hours. For a complete medical eye exam, dilation of your eyes will be required, which can cause temporary light sensitivity and/or blurred vision. Since the effect can last about 3 to 4 hours, we will provide you with a pair of disposable sunglasses. We also advise that you arrange for someone to drive you home since your near vision will be blurry.

If we are contracted with your specific health insurance plan, your medical eye exam may be covered. As a courtesy, we will bill your insurance for the services provided. All applicable co-payments or deductibles will be collected from you at the time of your visit. If you are deemed ineligible for your insurance benefits at the time of service, you will be responsible for payment prior to being examined. If there are any changes to your insurance plan, please inform us immediately.

We are currently an Out-of-Network provider with ALL vision insurance plans (e.g., VSP, EyeMed). Payments will be collected at the time of service. Refractions (exams to check or update your prescription for eyeglasses) and contact lens fittings are offered for an out-of-pocket charge and payment will be collected at the time of service.

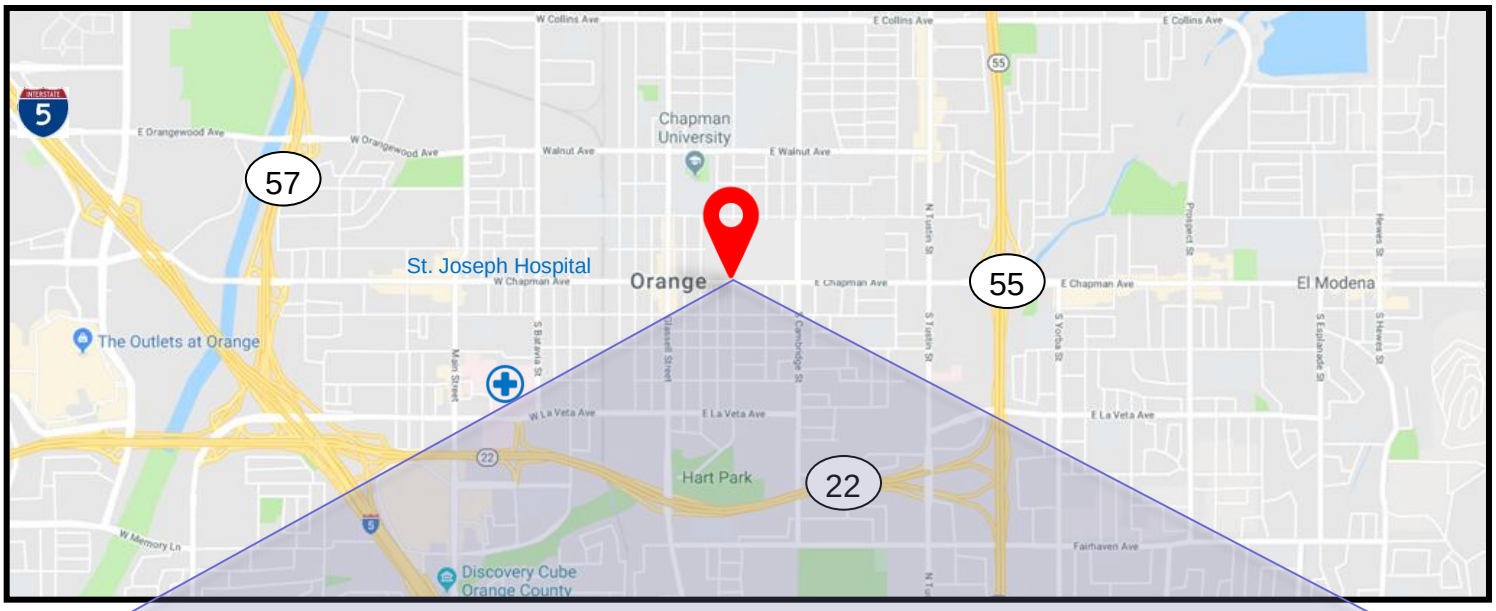
If you need to reschedule your appointment, please give us at least 24 hours notice by calling our office at (714) 769-6386. Any cancellations made less than 24 hours of your appointment or any missed appointments will be charged a $125 fee. We look forward to taking care of you.

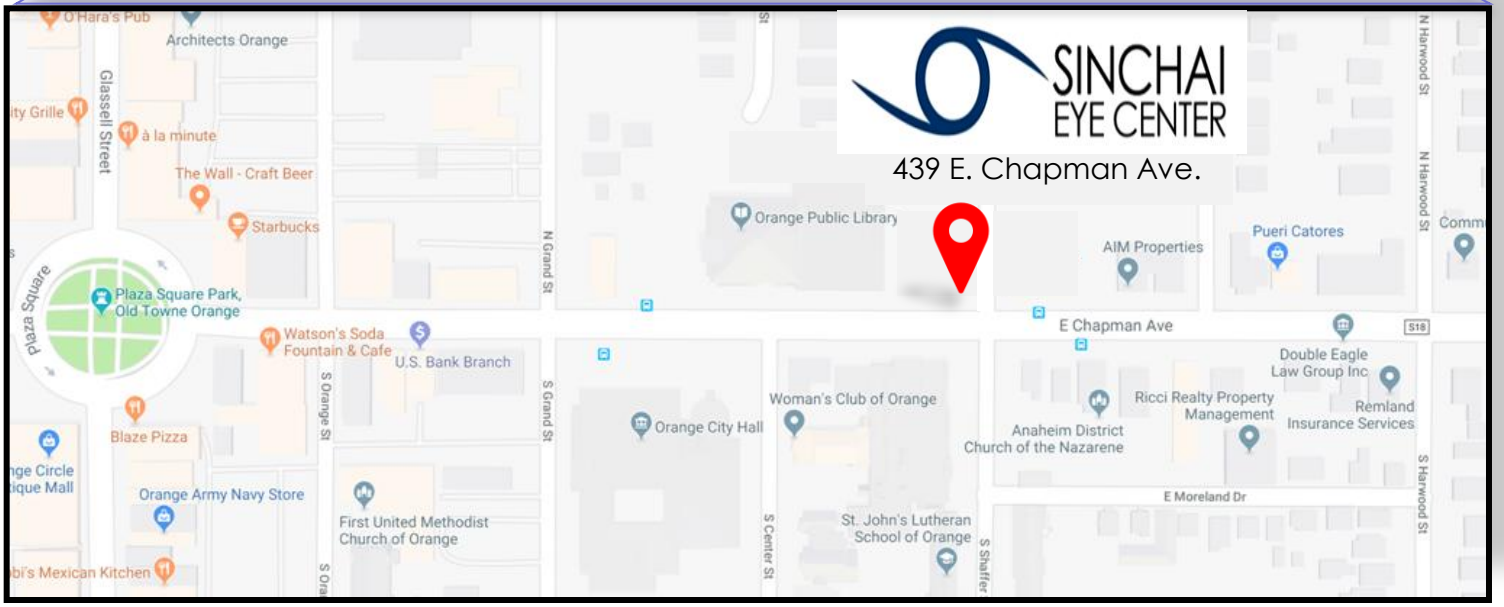
Sincerely,

Oat Sinchai, M.D.

MAP

439 E. Chapman Ave., Orange, CA 92866
Tel: 714-769-6386 Fax: 714-769-6387





On the corner of E. Chapman Ave. and Shaffer St. (next to the Orange Public Library)
Parking lot in the rear of the building via Shaffer St.

Revised 08/27/19

SINCHAI EYE CENTER

ID #:

TODAY'S DATE:

PATIENT INFORMATION FORM

Please completely fill out this form to ensure the fastest and best healthcare service.

PATIENT NAME LAST	FIRST	MI
ADDRESS	**DATE OF BIRTH**	**AGE**
CITY/STATE/ZIP	**MARITAL STATUS** Single Married Divorced Widowed	**GENDER** M F
PRIMARY PHONE # _____ *CELL / HOME / WORK*	**SECONDARY PHONE #** _____ *CELL / HOME / WORK*	
SOCIAL SECURITY NUMBER	**EMPLOYER**	
EMAIL	**OCCUPATION**	

PRIMARY CARE PHYSICIAN

NAME: PHONE #: FAX #:

ADDRESS:

EMERGENCY CONTACTS

1. NAME: _____ PHONE:_____ RELATIONSHIP:_____

2. NAME: _____ PHONE:_____ RELATIONSHIP:_____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
POLICY TYPE: ☐ HMO ☐ PPO ☐ MEDICARE ☐ OTHER:_____	POLICY TYPE: ☐ HMO ☐ PPO ☐ MEDICARE ☐ OTHER:_____
INSURANCE NAME:	INSURANCE NAME:
MEMBER ID #:	MEMBER ID #:
GROUP #:	GROUP #:
COPAY (Specialist):	COPAY (Specialist):

POLICY SUBSCRIBER (other than the patient):	
NAME:	PHONE:
DATE OF BIRTH:	RELATIONSHIP TO PATIENT:

HOW WERE YOU REFERRED TO OUR PRACTICE?

☐ PRIMARY CARE PHYSICIAN ☐ OTHER PHYSICIAN: Name _____ ☐ INTERNET ☐ INSURANCE

☐ FAMILY OR FRIEND: Name _____ ☐ OTHER: _____

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PATIENT RESPONSIBILITY

Agreement of Responsibility

I understand that professional services are rendered to the patient and that the patient is responsible for charges incurred for these services. Payment for annual deductibles and Co-Insurance will be collected at the time of service.

I certify that the information provided is accurate and I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treatment

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information / Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due from me.

Signature: _____

Signature – Patient or Representative

This Consent was signed by: _____

Printed Name – Patient or Representative

Relationship to Patient (if other than Patient): _____

Date: _____ Confirmed by: _____

Printed Name – Practice Representative

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PATIENT HEALTH HISTORY FORM (page 1 of 2)

TODAY'S DATE:

PATIENT NAME Last First MI

Past Medical History (Please check or circle all that apply)

NONE (please circle if none apply)
Allergies: _____
Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH (Enlarged Prostate)
Breast Cancer
Colon Cancer
COPD (Lung Disease)
Coronary Artery (Heart) Disease
Depression
Diabetes
End Stage Renal Disease
Other:

GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension (High BP)
Hypotension (Low BP)
HIV / AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Medications (Please list **ALL** current medications, **including eye drops**)

Drug Allergies ☐ YES ☐ NO

If yes, please specify:

Past Surgeries (Please check or circle **AND** note the year performed)

NONE (please circle if none apply)
Appendix : (Appendectomy)
Bladder : (Cystectomy)
Breast - Breast Biopsy: R / L / Both
Breast - Lumpectomy: R / L / Both
Breast - Mastectomy: R / L / Both
Colon (Colectomy) : Colon Cancer Resection
Colon (Colectomy) : Diverticulitis
Colon (Colectomy) : Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder : (Cholecystectomy)
Heart : Biological Valve Replacement
Heart : Coronary Artery Bypass Surgery
Heart : Heart Transplant
Heart : Mechanical Valve Replacement
Heart : PTCA (Stent)
Joint Replacement - Hip: R / L / Both
Joint Replacement - Knee: R / L / Both
Kidney - Kidney Biopsy: R / L / Both
Kidney - Kidney Stone Removal: R / L / Both
Kidney - Kidney Transplant: R / L / Both
Kidney - Nephrectomy: R / L / Both
Liver : Hepatectomy
Other:

Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy) : Endometriosis
Ovaries (Oophorectomy) : Ovarian Cancer
Ovaries (Oophorectomy) : Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy) : Prostate Biopsy
Prostate (Prostatectomy) : Prostate Cancer
Prostate (Prostatectomy) : TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin : Basal Cell Carcinoma
Skin : Melanoma
Skin : Skin Biopsy
Skin : Squamous Cell Carcinoma
Spleen : (Splenectomy)
Testicles : (Orchiectomy)
Uterus (Hysterectomy) : Full / Partial
Uterus (Hysterectomy) : Fibroids
Uterus (Hysterectomy) : Uterine Cancer
Uterus (Hysterectomy) : Cervical Cancer

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PATIENT HEALTH HISTORY FORM (page 2 of 2)

TODAY'S DATE:

Past Ocular History (Please check or circle all that apply)

NONE (please circle if none apply)
Allergic Conjunctivitis
Blepharitis / Dry Eyes / Both
Cataract: R / L / Both
Chalazion: R / L / Both
Contact Lenses / Glasses / Both
Corneal Dystrophy: R / L / Both
Diabetic Retinopathy, Background
Diabetic Retinopathy, Proliferative
Glaucoma: R / L / Both
Macular Degeneration: R / L / Both
Macular Pucker (ERM): R / L / Both
Narrow Angles: R / L / Both
Ocular Hypertension: R / L / Both
Ophthalmic Migraine
Ocular Trauma: R / L / Both
Pseudoexfoliation
Pterygium: R / L / Both
Retinal Tear/Detachment: R / L / Both
Strabismus
PVD: R / L / Both
Vitreous Floaters: R / L / Both
Other:

Ocular Surgeries (Please check or circle **AND** note the year performed)

NONE (please circle if none apply)
Blepharoplasty: R / L / Both
Cataract Surgery: R / L / Both
Chalazion Removal: R / L / Both
Corneal Transplant: R / L / Both
DSAEK: R / L / Both
Eye Muscle Surgery
Intravitreal Injections: R / L / Both
LASIK: R / L / Both
LPI (Iris – Glaucoma): R / L / Both
LTP (Angle – Glaucoma): R / L / Both
PRK: R / L / Both
Pterygium Surgery: R / L / Both
Ptosis Repair: R / L / Both
Punctal Plugs: R / L / Both
Strabismus Surgery
Retinal Laser: R / L / Both
Trabeculectomy (Glaucoma): R / L / Both
Tube Shunt (Glaucoma): R / L / Both
YAG Capsulotomy: R / L / Both
Other:

Social History (Please check or circle all that apply)

Cigarette Smoking:
Never smoked
Former smoker, but quit in year _____
Currently smokes
_____ packs per day / week

Alcohol Use:
NONE
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Recreational/illicit drug use:
☐ YES ☐ NO
If yes, please specify:

Family History (mother/father/sister/brother/daughter/son):
Diabetes
High blood pressure
Heart disease
Glaucoma
Retinal detachment
Vision loss/blindness

Language: English Spanish Other:

Race/Ethnicity: Hispanic/Latino Black/African American White Asian Other:

Pharmacy name:

Address or Cross Streets:

Phone #: **City or Zip Code:**

Review of Systems (Please check or circle all that apply)

Poor Vision
Eye Pain
Redness
Tearing
Jaw Pain
Scalp Tenderness
Fever
Weight Loss
Dry Mouth
Stuffy Nose
Congestion
Cough
Shortness of Breath
High Blood Pressure
Rapid Heart Beat
Upset Stomach
Diarrhea
Constipation
Rash
Changing Moles
Headache
Seizure
Stroke
Paralysis
Urinary Frequency
Incontinence
Joint Pains
Thyroid Abnormalities
Bleeding
Anxiety
Depression
Allergies

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PHYSICIAN-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 necessary 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 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 partners, 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.

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 or 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 joiner in this arbitration of any person or entity, which would otherwise be a proper additional party in court action, and upon such intervention and joiner 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 statue 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.

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 OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____
Signature – Patient or Representative	Signature – Practice Representative
_____	_____
Printed Name – Patient or Representative	Printed Name – Practice Representative
_____	_____
Date	Date

SINCHAI EYE CENTER

ID #:

PATIENT PRIVACY

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Oat Sinchai, M.D. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including accessing your medication history through your pharmacy.
- Oat Sinchai, M.D. has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Oat Sinchai, M.D. reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but Oat Sinchai, M.D. does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Oat Sinchai, M.D. may condition treatment upon the execution of this Consent.

_____ _____ _____

Patient's Signature | Date of Birth | Date

_____

Printed Name

If the patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Signature of Legal Guardian | Legal Relationship | Date of Birth | Date

_____

Printed Name

AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH OF INFORMATION

Patient Name: _____ Date of Birth: _____
Last First Middle

I voluntary authorize and direct the eye doctor (ophthalmologist or optometrist) named below to disclose my medical records to the recipient that I have identified below.

Name of Eye Doctor (Ophthalmologist or Optometrist): _____

Address of Eye Doctor: _____

_____

Phone Number: _____ **Fax Number:** _____

RECIPIENT FOR DELIVERY OF RECORDS:

SINCHAI EYE CENTER
Oat Sinchai, M.D.
439 E. Chapman Ave.
Orange, CA 92866
Tel: 714-769-6386 Fax: 714-769-6387

Information to be disclosed: This authorization permits the above named eye doctor (ophthalmologist or optometrist) to disclose all of my health information that the doctor has in his/her possession, **INCLUDING ALL RECORDS OF ANY VISUAL FIELD TESTING, RETINAL NERVE FIBER LAYER SCAN (e.g., OCT, GDX, HRT), INTRAOCULAR LENS IMPLANT CALCULATIONS FOR CATARACT SURGERY, AND CHART NOTES**.

_____ _____
Patient Signature Date

_____
Patient Printed Name

If the patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Signature of Responsible Party Legal Relationship Date

_____ _____
Printed Name of Responsible Party Witness Signature

SINCHAI EYE CENTER

ID #:

PRIVACY OF PERSONAL HEALTH INFORMATION

Our medical practice collects medical and related identifiable patient information and stores it electronically on a computer. This information is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As a patient of our practice, you have the right to request that you receive your health information in a specific way. Our practice is committed to maintaining the privacy of your health information.

PHONE

May we leave a message on your voicemail at home, work and/or cell phone and/or email message regarding (Please mark and circle your preferences):

- Your upcoming appointments? □ **YES** (Home / Work / Cell / Email) □ **NO**
- Your lab results? □ **YES** (Home / Work / Cell / Email) □ **NO**
- Your insurance or billing? □ **YES** (Home / Work / Cell / Email) □ **NO**

Home _____ Work _____ Cell _____

Email _____

May we leave messages regarding your appointments, results, or billing information with another person?

□ **NO**
□ **YES** _____ _____
Printed Name Relationship

MAIL

Please send mail regarding your appointments and test results to the following address:

_____

_____

_____ _____ _____
Patient's Signature Date of Birth Date

_____
Printed Name

If the patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Signature of Legal Guardian Legal Relationship Date of Birth Date

_____
Printed Name

SINCHAI EYE CENTER

ID #:

Appointment Cancellation and No-Show Policy

We reserve the right to charge a fee to patients who fail to show or cancel/reschedule an appointment with less than a 24 hours' notice. This fee is in the amount of $125.

This fee will be the patient's responsibility and will be due ***before or at the time*** of patient's next office visit.

Should you need to cancel or reschedule an appointment, please contact our office ***no later than 24 hours prior*** to your scheduled appointment. This provides an opportunity for our staff to offer an appointment to other patients who may be waiting to be seen.

As a courtesy, every patient is offered a text message reminder for all scheduled appointments. If the patient chooses not to receive a text message, it is the patient's responsibility to remember their appointment date and time. The Appointment Cancellation and No-Show Policy will remain in effect should the patient not receive a text message.

We understand you may not be able to keep an appointment due to unforeseen illnesses or emergencies. Please contact our office as soon as possible should you experience any extenuating circumstances so we can make the appropriate documentation.

Please sign below confirming that you have read and fully understand the Appointment Cancellation and No-Show Policy. This form will be used as a reference to validate this agreement.

Signature: _____
Signature – Patient or Representative

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than Patient): _____

Date: _____ Confirmed by: _____
Printed Name – Practice Representative