SINCHAI EYE CENTER

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

RHEELA KIM, O.D.
Optometrist

STELLA MA, O.D.
Optometrist

WELCOME TO OUR PRACTICE

(IMPORTANT – PLEASE READ THOROUGHLY!)

We look forward to seeing you. In order to provide you with the best quality care and reduce your wait time, **please complete and submit the following pages at least 1 WEEK PRIOR to your appointment**:

- ❏PATIENT HEALTH HISTORY FORM
- ❏PATIENT INFORMATION FORM
- ❏PATIENT RESPONSIBILITY/PATIENT PRIVACY/APPOINTMENT CANCELLATION & NO-SHOW POLICY

Please bring your **insurance cards** and **ID card/driver's license** with you on the day of your visit, along with your current eyeglasses and/or contact lens prescriptions, as well as 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 may cause temporary light sensitivity and/or blurred visión. 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 vision may be blurry.

If we are contracted with your health insurance plan, your medical eye exam may be covered. As a courtesy, we will bill your insurance for the services provided. All applicable copayments or deductibles will be collected from you at the time of your visit. You may choose to keep your credit card information securely on file to pay for any future balances or deductibles owed. 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.

Refractions (exams to measure and update your prescription for eyeglasses) will not be performed on your initial visit. However, you have the option to schedule a separate refraction appointment after your initial medical eye exam so that we can first screen you for any potential eye diseases. Refractions are only offered for an out-of-pocket charge and payment will be collected at the time of service since we are not currently contracted with any vision insurance plans (e.g., VSP, EyeMed).

We look forward to your visit with us!

439 E. Chapman Ave.
Orange, CA 92866
T: (714) 769-6386 F: (714) 769-6387
info@sinchaieye.com

SINCHAI EYE CENTER

PATIENT HEALTH HISTORY FORM

Date:

Last Name: **First Name:** **Middle Initial:**

Reason for your visit (Please check or circle all that apply)

Cataract Evaluation
Blurred Vision / Vision Loss
Floaters and/or Light Flashes
Diabetic Eye Exam
Glaucoma Evaluation
General Eye Exam
Eye Pain / Irritation / Dryness
Eye Redness
Tearing
Other:

Ocular History (Please check or circle all that apply)

Cataracts
Blepharitis / Dry Eyes
Contact Lenses / Glasses
Diabetic Retinopathy
Glaucoma
Macular Degeneration
Epiretinal Membrane / Macular Pucker
Ocular Injury / Trauma
Vitreous Floaters
Retinal Tear / Detachment
Strabismus / Lazy Eye
Other:

Ocular Surgeries (Please note the year performed)

Cataract Surgery
LASIK PRK RK
Retinal Surgery Laser Injection
Glaucoma Surgery Laser
Other:

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

Diabetes
Hypertension (High BP)
BPH (Enlarged Prostate)
Auto-Immune Disease Lupus Other
Atrial Fibrillation (Irregular Heartbeat)
Asthma or COPD (Lung Disease)
Coronary Artery (Heart) Disease
Anxiety
Arthritis
Hearing Loss
Cancer (specify type):
Stroke
Thyroid Disease
Other:

Past Non-Ocular Surgeries (Please list and note year performed)

Drug Allergies (Please check or circle all that apply)

None Sulfa Other:
Penicillin Codeine

Medications (Please list ALL current medication below, including eye drops OR bring your own medication list)

Social History (Please check or circle all that apply)

Cigarette Smoking:

Never smoked
Former smoker - quit in year __________
Current smoker: ___ packs per day / week

Alcohol Use: NONE

___ drinks per day

Recreational/illicit drug use:

YES NO

If yes, please specify:

Family History (mother/ father/ sister/ brother/ daughter/ son):

Blindness Retinal Detachment
Glaucoma Other:

Language: English Spanish Other:

Race/Ethnicity: Amer. Indian Asian Hispanic/Latino
White Black/African American Pac. Islander/Hawaiian
Decline to answer Other:

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

Headache Shortness of Breath Incontinence
Jaw Pain Diarrhea Joint pain
Scalp Tenderness Constipation Thyroid
Fever Rash Anxiety
Weight Loss Seizure Depression
Cough Stroke Other:

SINCHAI EYE CENTER

PATIENT INFORMATION FORM

LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL:**

ADDRESS	**DATE OF BIRTH**	**AGE**
CITY / STATE / ZIP CODE	**MARITAL STATUS** Single Married Divorced Widowed	**GENDER** Male Female

PRIMARY PHONE: *CELL* *HOME* *WORK*	**SECONDARY PHONE:** *CELL* *HOME* *WORK*
SOCIAL SECURITY NUMBER	**OCCUPATION**
EMAIL	**EMPLOYER**

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
INSURANCE COMPANY NAME:	INSURANCE COMPANY NAME:
POLICY TYPE: HMO PPO OTHER:	POLICY TYPE: HMO PPO OTHER:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DATE OF BIRTH:	SUBSCRIBER DATE OF BIRTH:
SUBSCRIBER RELATIONSHIP TO PATIENT:	SUBSCRIBER RELATIONSHIP TO PATIENT:
ID#:	ID#:
GROUP#:	GROUP#:

PRIMARY CARE PROVIDER NAME:

CITY: PHONE:

OPTOMETRIST NAME:

CITY: PHONE:

HOW WERE YOU REFERRED TO OUR PRACTICE?:

PRIMARY CARE PROVIDER OTHER PHYSICIAN OR OPTOMETRIST: Name ____

INSURANCE FAMILY OR FRIEND: Name ____

GOOGLE YELP FACEBOOK OTHER: ____

PHARMACY NAME: PHONE:

ADDRESS OR CROSS STREETS: CITY:

EMERGENCY CONTACT / DESIGNATED INDIVIDUALS RELEASE:

I authorize Sinchai Eye Center to release my protected health information (PHI) to the following designated individual(s) in the event of an emergency or for purposes related to my medical care. I understand I may revoke this authorization at any time in writing. This may include verbal, written, or email communications regarding (please check at least one of the following options or all that apply):

ALL MY PROTECTED HEALTH INFORMATION (PHI)

TREATMENT/APPOINTMENTS ONLY PAYMENT/BILLING INFORMATION ONLY HEALTHCARE OPERATIONS ONLY

DESIGNATED INDIVIDUAL(S):

NAME: RELATIONSHIP: PHONE:

NAME: RELATIONSHIP: PHONE:

I DO NOT AUTHORIZE THE RELEASE OF MY PHI TO ANY INDIVIDUAL

SIGNATURE: DATE:

PATIENT RESPONSIBILITY

Agreement of Responsibility

I understand that professional services are rendered to me and that I am responsible for charges incurred for these services.
I understand that payment for annual Deductibles and Coinsurance will be collected at the time of service.
I understand that a finance charge of 5% per month will be charged on all account balances not paid within 30 days.

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

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.

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.

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

If you need to cancel or reschedule your appointment, please be considerate and contact our office ***at least 24 hour before*** your scheduled appointment time. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you and your health care is important to us.

If you do not cancel your appointment with at least 24 hour advance notice or you fail to keep your appointment, you will receive a charge of $50.00 which must be paid prior to rescheduling. If this occurs, we reserve the right to keep your credit card on file.

Please sign below to confirm that you have read, fully understand and agree to the Patient Responsibility, Patient Privacy, and Appointment Cancellation/No-Show Policy.

Signature: Date:

AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH OF INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

Last First Middle

I voluntarily authorize and direct the eye doctor (*ophthalmologist or optometrist*) named below to disclose my medical records to **SINCHAI EYE CENTER**:

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.

THIS INCLUDES 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

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE ADDRESSEE LISTED ABOVE AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL, AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS MESSAGE IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AT THE NUMBER ABOVE AND DESTROY ALL COPIES OF THE ORIGINAL FAX.