YANG
EYE ASSOCIATES

Yang Eye Associates
950 Northgate Dr Ste 209
San Rafael, CA 94903
Tel: (415) 479-2372
Fax: (415) 472-6225

PERSONAL		
Last Name:	First Name:	
Gender:	Date of Birth:	
Address:		
City:	State:	Zip Code:
Mobile Phone:	Home Phone:	
Email Address:	SSN:	
Emergency Contact: Phone Number: Relationship:	Employer: Occupation:	

HEALTH INFORMATION	
Referral:	Preferred Pharmacy:
Primary Care Physician: Phone Number:	Optometrist: Phone Number:
Primary Insurance: ID:	Secondary Insurance: ID:

ACKNOWLEDGEMENT OF PRIVACY PRACTICE AND HIPAA AUTHORIZATION

I hereby acknowledge that I understand this medical practice's Notice of Privacy Practices (the "Notice"). This Notice describes how we might use or disclose your protected health information, and your rights and our duties with respect to this information. You have the right to review the Notice before signing this acknowledgment.

Signature _____ Today's Date _____

HIPAA (Health Insurance Portability and Accountability Act) allows us to release information to certain outside entities on your behalf. Otherwise by law, we are not permitted to release any medical information except to those individuals authorized by you and listed below. I understand that Yang Eye Associates is not responsible for the information once it is given to an authorized person. Relation/Date of Birth are needed so that our office can verify that we are speaking to the correct person.

Name: _____ Relation: _____ Date of Birth: _____

☐ I DO NOT authorize Yang Eye Associates to release ANY of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

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OFFICE POLICIES

LATE ARRIVALS

If you are more than 15 minutes late for your appointment time, we may need to reschedule your appointment in fairness to other scheduled patients and the need to have sufficient time to complete your exam.

MISSED APPOINTMENTS

Missed appointments are lost opportunities for other patients. For new patients, there is a $85 charge for appointments missed without prior notice. For our established patients, you are allowed two missed appointments; to schedule a third appointment, you will need a credit card on file and there will be a $85 charge for missing your appointment.

CO-PAYMENTS

Insurance companies require us to collect your co-payment at the time of your visit. If you wish us to bill you for this co-payment, please inform us.

FEES

There is a $20.00 fee per form for completion of DMV, state disability, or miscellaneous paperwork.

RETURNED CHECKS

Patients with checks returned unpaid from the bank will be charged $50.00 per check to cover bank fees and processing.

OUTSTANDING BALANCES

Account balances outstanding beyond 30 days after the date billed are subject to interest at a rate of 1½% per month. Unpaid balances past 90 days are automatically sent to an outside collection agency.

CONTACT LENSES

Contact lens services may not be covered by your insurance company. Details of these fees are available on our Contact Lens Information Sheet.

SIGNATURE

My signature is contract that I have read, as well as understand and agree to the above.

Name	Signature

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FINANCIAL AGREEMENT

As a courtesy, the office will bill your insurance for you. A current copy of your insurance card is required at your date of service for our office to bill your insurance directly. Payment in full is due at your appointment if you are not able to provide us with a copy of your current insurance. Should your insurance need more information or deny the claim, it is the patient's responsibility to comply with the insurance company to provide needed information and/or pay for the charge in full.

As the patient, any charges that are not covered by your insurance are your responsibility and you are financially responsible. It is the patient's responsibility to verify insurance coverage before the time of service. If we are not providers under your insurance or if your insurance refuses to pay based on health benefits provided, complete payment is your responsibility despite the insurance company's arbitrary calculation of UCR (Usual, Customary, and Reasonable) rates.

WE DO NOT ACCEPT: MEDI-CAL INSURANCE (Partnership)**, VISION INSURANCE** (VSP, EyeMed etc.)
Our office is not contracted with Medi-Cal. If Medi-Cal is your primary insurance coverage, we are unable to bill to Medi-Cal for services rendered, except for emergencies. By signing this agreement, you agree to pay for services rendered at this office in full and will be considered a self-pay patient. If Medicare is your primary insurance and Medi-Cal is secondary, we will bill Medicare for services rendered. However, you are financially responsible for all non-covered charges.

If you are a cash pay patient because you do not have insurance or we are not providers for your insurance, payment in full is due at the time of service.

Complete payment for known amounts, such as co-payments and non-covered charges, are due at your scheduled appointment. Coinsurance and deductible amounts vary with each insurance company and cannot be determined until after claim submission. Payment for these amounts are expected within 30 days of receiving a billing statement. It is the patient's responsibility to update any demographic information necessary.

Our service fees are rendered as usual and customary for our geographic area. If you have any questions regarding your insurance information or financial standing with our office, please contact our billing company.

The Open Payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

My signature is contract that I have read, as well as understand and agree to the above.

Name	Date of Birth
Signature	Today's Date

If not signed by the patient, please indicate relationship: _____

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MEDICAL HISTORY

Allergies: ☐ NONE ☐ YES: List all medications that have caused an allergic reaction.

Medications: ☐ NONE ☐ YES: List all medications, including over-the-counter, vitamins, and supplements.

Do you give Yang Eye Associates consent to import your medication history from SureScripts? ☐ YES ☐ NO

Eye Drops: ☐ NONE ☐ YES: List all eye drops, including artificial tears and over-the-counter drops.

Major Illnesses and Injuries: ☐ NONE

☐ Arthritis ☐ Asthma ☐ Autoimmune Disease ☐ Prostate Disease ☐ Cancer ☐ Chronic Bronchitis
☐ Dementia ☐ Depression ☐ Diabetes ☐ Emphysema ☐ Heart Disease ☐ Genitourinary Disease
☐ High Cholesterol ☐ HIV ☐ Hypertension ☐ Neurological Disease ☐ Lung Disease ☐ Thyroid Disease
☐ Stroke ☐ Skin Disease ☐ Ear, Nose, Throat, Mouth Disease ☐ Gastrointestinal Disease
☐ Other: Please List all illness below.

Past Surgical and Hospitalizations in the Past 3 Years: ☐ NONE ☐ YES: Please list them below.

Are you pregnant? ☐ NO ☐ YES: ____ Months

Social History:
☐ Use tobacco, duration:
☐ Drink alcohol, amount:
☐ Use recreational drugs, amount:
☐ Been infected with HIV, exposure date: