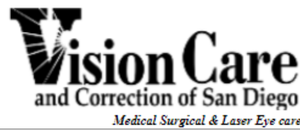
TODAYS DATE
/ /



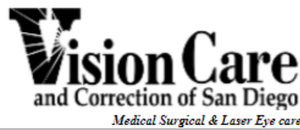
PATIENT REGISTRATION			
LEGAL NAME:	*LAST*	*FIRST*	*MIDDLE*
DATE OF BIRTH:	/ /	**SOCIAL SECURITY NUMBER:**	_ _
SEX ASSIGNED AT BIRTH:	☐MALE ☐FEMALE	**GENDER IDENTITY:**	*(Optional):*
SEXUAL ORIENTATION	*(Optional):*	**PREFERRED PRONOUN:**	*(Optional):*
MARITAL STATUS:	☐MARRIED ☐SINGLE ☐DIVORCED ☐SEPERATED ☐WIDOWED	**PREFERRED LANGUAGE:**	☐ENGLISH ☐SPANISH ☐OTHER
E-MAIL:	@	**PHONE NUMBER(S):**	
ADDRESS:			
CURRENT OCCUPATION:			
EMERGANCY CONTACT:	*(NAME)*	*RELATION:*	*PHONE NUMBER:*
Do you authorize Protected Health Information (PHI) to be discussed with this individual? ☐Yes ☐No			
Is there anyone else you would like to authorize PHI to be discussed with? ☐Yes ☐No		If yes, please list:	

PROVIDER AND PHARMACY DETAILS			
PRIMARY PHYSICIAN	*NAME*	*PHONE*	*FAX*
REFERRING PHYSICIAN	*NAME*	*PHONE*	*FAX*
PREFERRED PHARMACY	*NAME*	*PHONE*	*FAX*

INSURANCE COVERAGE			
Who is the Subscriber under your health insurance?		☐ Self ☐Spouse ☐Parent/Guardian	
PRIMARY	*INSURANCE NAME:*	**POLICY NUMBER**	
SECONDARY	*INSURANCE NAME*	**POLICY NUMBER**	
VISION	☐VISION SERVICE PLAN (VSP) ☐MEDICAL EYE SERVICES (MES)	**SPONSOR SSN**	

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Michael T. Couris, MD, INC, to be applied to my account for services rendered. <u>I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.</u> I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	
DATE	



CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

PRIVACY OFFICER: ADAN MARTINEZ
PHONE NUMBER: 619-291-6191

I consent to the use or disclosure of my protected health information by Michael T. Couris, MD, INC., Steven Giang OD, Inc., Suzanne P. Handler, MD, INC., Kelly S. Keefe, MD, Inc. and Courique Optical (*) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations at this office. I understand that diagnosis or treatment of me by the physicians in this office may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or healthcare operations in this office. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding on this office.

I have the right to revoke this consent in writing at any time except to the extent that, Michael T. Couris, MD, INC., Steven Giang OD, Inc., Suzanne P. Handler, MD, INC., Kelly S. Keefe, MD, Inc., has taken action in reliance on this consent.

My “protected Health Information” means health information including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. Protected health information relates to information about my past, present, or future physical or metal health condition which identifies me, or where there is a reasonable basis to believe the information may identify me.

I have the right to review this office’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for this office is also provided by request. The Notice of Privacy Practices also described my rights and The Office’s duties with respect to my protected health information.

The office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting Adan (Privacy Officer) and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*”This Office” refers to Courique Optical, Michael T. Couris, MD, INC., Steven Giang OD, Inc., Suzanne P. Handler, MD, INC., Kelly S. Keefe, MD, Inc.

I hereby permit, Michael T. Couris, MD, INC., or Steven Giang OD, Inc., or Suzanne P. Handler, MD, INC. or Kelly S. Keefe, MD, Inc. access to my medical records. I understand I may revoke this permission at any time

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	
NAME OF PATIENT OR PERSONAL REPRESENTATIVE	
DATE	

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, read, and understand this medical practice’s Notice of Privacy Practices. I also understand that this copy of the current notice will be stored in my medical record and can be made available upon request at each appointment.

SIGNATURE OF ACKNOWLEDGEMENT	

Vision Care
and Correction of San Diego
Medical Surgical & Laser Eye care

FINANCIAL & OFFICE POLICY	
OFFICE VISITS:	All co-payments, deductible amounts, and all outstanding account balances will be collected at the front desk prior to service. Secondary insurances will be billed as a courtesy to you, but all pre-collected amounts will be based solely on your primary insurance, with any duplicate payments being refunded to you should they occur. If your insurance has a percentage coinsurance, or unknown co-pay, we reserve the right to collect $30 estimated deposit towards your amount owed. If we are not contracted with your insurance company, if you do not have insurance coverage, or if there is a history of delayed prior balance remittance or a bounded check, a deposit will be collected at the front desk for the full estimated charges for the current visit.
PAYMENT RESPONSIBILITY:	Payments for any patient responsibility balances are due within 15 days of statement date. Payments may be de by cash, personal check, debit care, VISA, or Mastercard. You are financially responsible for any charges not covered by your insurance carriers(S), including co-pays, deductibles and/or non-covered services. If for any reason your insurance carrier(s) has not paid within 90 days from the initial date of submission of charges to them, if requested, you must pay the amount full at that time, with a duplicate payment being refunded o you should they occur. If your account becomes delinquent, we may refer your account to a collection agency.
PROCEDURES:	If you are scheduled for a non-emergent procedure or surgery, we will check your insurance benefits and advise you of your estimated financial responsibility to Dr. Couris based on your primary insurance. Secondary insurances will be billed as a courtesy to you, but all pre-collected amounts will be based solely on your primary insurance, with any duplicate payments being refunded to you should they occur. All co-pays, deductible amounts, and outstanding account balances will be required at the time of your in-office procedure, or for hospital procedures, at your pre-op appointment.
FLMA & DISABILITY FORMS:	There will be a $20 charge for the completion of each FMLA and disability form, payable when forms are dropped off at the office.
CHANGE OF ADDRESS:	It is your responsibility to promptly notify us of any address changes. If your account becomes delinquent because we do not have current address, you will be responsible for all reasonable costs and consequences of collections
RETURNED CHECKS:	There will be a $40 charge added to your account for any check returned for insufficient funds, Additionally, checks would no longer be an acceptable form of payment.
MISSED APPOINTMENTS:	Repeated missed appointments not canceled prior to 24 hours before the appointment will result in discharge from the practice.

FAILURE TO COMPLY WITH THIS FINANCIAL POLICY WILL RESULT IN DISHCRAGE FROM THE PRACTICE.
PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND OUR FINANCIAL POLICY.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	
DATE	

PATIENT MEDICAL INFORMATION SHEET			
PATIENT NAME		**DATE OF BIRTH**	
REASON FOR VISIT? *(INLUDE EYE(S) INVOLVED & DURATION OF SYMPTOMS)*			

OCULAR HISTORY			
GLASSES	☐BIFOCALS ☐PROGRESSIVE ☐SINGLE VISION	**CURRENT GLASSES PRESCRIPTIONN**	YRS OLD
CONTACTS	☐SOFT ☐RGP BRAND:	**AVERAGE WEARTIME:**	MIN/ HRS
OCULAR SURGERIES:			

CURRENT EYE DROPS		
1.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY
2.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY
3.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY

CURRENT MEDICATIONS *(OTHER THAN EYE MEDICATIONS)*	
1.	**4.**
2.	**5.**
3.	**6.**
ALLERGIES TO MEDICATIONS? ☐Yes ☐No	*IF YES, PLEASE LIST.*

MEDICAL REVIEW OF SYMPTOMS *(CHECK ALL THAT APPLY)*		
☐**ARRHYTHEMIA**	☐**HYPERTENSION**	☐**THYOID**
☐**STROKE**	☐**SEIZURE**	☐**ARTHRITIS**
☐**CANCER**	☐**ANGINA**	☐**OSTEOPOROSIS**
☐**ASTHMA**	☐**HEART ATTACK**	☐**ANEMIA**
☐**EMPHYSEMA**	☐**BLEEDING TENDANCY**	☐**HIV +VE**
☐**DIABETES;** what was your last HbA1C________and Glucose________	☐**CONGESTIVE HEART FAILURE**	☐**GASTROINTESTINAL**

DO YOU SMOKE? ☐Yes ☐No	*IF YES, HOW OFTEN?*	**DO YOU DRINK ALCOHOL?**☐Yes ☐No	*IF YES, HOW OFTEN?*

FAMILY HISTORY(*NOT INNCLUDING YOURSELF, CHECK ALL THAT APPLY)*		
☐ **RETINAL DETACHMENT**	**RELATIONSHIP**	
☐ **MACULAR DEGNERATION**	**RELATIONSHIP**	
☐ **GLAUCOMA**	**RELATIONSHIP**	
☐ **CATARACT**	**RELATIONSHIP**	
☐ **DIABETES**	**RELATIONSHIP**	