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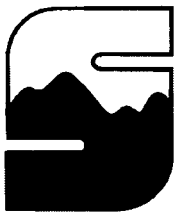

SIERRA EYE GROUP
SIERRA EYE MEDICAL GROUP, INC.
2830 WEST MAIN STREET
VISALIA CALIFORNIA 93291
TELEPHONE (559) 636-1000
FAX (559) 636-3937

Sierra Eye Medical Group
Registration Materials

The following documents are included for you to consider and /or fill out:

- Patient Registration Form
- Financial Disclosure Document
- Medical History Form
- Patient Financial Agreement
- Acknowledgement of Notice of Privacy Practices (NPP)
  (To view our NPP, go to www.sierraeye.com and follow the links)

Please fill out the applicable forms completely. Upon completion, please do one of the following:

FAX to (559) 636-3937

or

Mail to:

New Patient Registration
Sierra Eye Medical Group, Inc.
2830 West Main Street
Visalia, CA 93291-4300

or

Bring the forms with you on your first visit

If you need directions to our office, please go to www.sierraeye.com and follow the links to the direction page.

Thank you for choosing Sierra Eye Group for your eye care.

REGISTRATION FOR SIERRA EYE MEDICAL GROUP, INC.

(for office use only)
Acct # _____
Chart # _____

Are you a new patient in this office? ❑ Yes ❑ No

Name of patient _____
First Middle Last

Patient's mailing address _____
Street No. City State Zip

Patient's street address _____
Street No. City State Zip

❑ Male
❑ Female Phone No. _____ Age _____ Birth date _____ Patient's SSN _____

Father's name _____ Father's SSN & D.O.B. _____

Father's employer _____ Father's occupation _____

Employer's address _____ Phone No. _____

Mother's name _____ Mother's SSN & D.O.B. _____

Mother's employer _____ Mother's occupation _____

Employer's address _____ Phone No. _____

Referred by _____
Do we have your permission to thank the person who referred you? ❑ Yes ❑ No

Patient's family physician _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ SSN _____

Address _____
Street No. City State Zip

INSURANCE INFORMATION

Name of insurance company _____ Policy# _____

Insured party name _____

Insured party DOB _____ Insured party SSN _____

FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to Sierra Eye Medical Group, Inc. where applicable, but without their assuming responsibility for the collection thereof. I authorize payment of medical benefits to Sierra Eye Medical Group, Inc. I authorize the release of any medical information necessary to process claims. This agreement remains valid until revoked in writing by me. A copy of this agreement is as valid as the original.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth on the reverse side.

Signature _____ Date _____
Responsible Person

(Please see reverse side)

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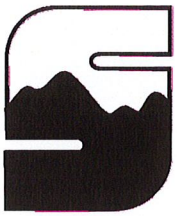

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Name: _____ **Date:** _____

Name of your personal physician or clinic you attend: _____

MEDICAL HX

- ☐ Borderline Diabetes
- ☐ Diabetes
- ☐ Gestational Diabetes, Unspecified
- ☐ High Blood Pressure
- ☐ Hyperlipidemia
- ☐ Thyroid Disease
- ☐ Graves' Disease
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Transient Ischemic Attacks (TIA)
- ☐ Stroke in Brain
- ☐ Aneurysm
- ☐ Anemia
- ☐ Sleep Apnea, Unspecified
- ☐ Cancer
- ☐ BPH (Enlarged Prostate)
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Plaquenil (Hydroxychloroquine) Use
- ☐ Ankylosing Spondylitis
- ☐ Crohn's Disease
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematous
- ☐ Sarcoidosis
- ☐ Ulcerative Colitis
- ☐ Polymyalgia Rheumatica
- ☐ Ehlers-Danlos Syndrome
- ☐ Marfan's Syndrome
- ☐ Autism
- ☐ Dementia
- ☐ Hard of Hearing

Surgical HX

- ☐ None
- ☐ Amputation
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric Surgery
- ☐ Brain Shunt
- ☐ C-Section
- ☐ Cardiac Surgery
- ☐ Colon Resection
- ☐ Foot Surgery
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Hand Surgery
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Hernia Surgery
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Shoulder Surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Common Drug Allergy

- ☐ No Known Drug Allergies
- ☐ Phenylephrine
- ☐ Anesthetic
- ☐ Sulfa
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Sudafed
- ☐ Codeine
- ☐ Morphine
- ☐ Steroids
- ☐ Alphagan
- ☐ Azopt
- ☐ Beta Blockers
- ☐ Brimonidine
- ☐ Cosopt
- ☐ Ciprofloxacin
- ☐ Latanoprost
- ☐ Tobramycin

Allergy to substance

- ☐ Latex
- ☐ Fluorescein Dye
- ☐ ICG Dye
- ☐ Iodine
- ☐ Tape
- ☐ Pollen
- ☐ Dust
- ☐ Mold
- ☐ Mildew

Food Allergy

- ☐ Shellfish
- ☐ Dairy
- ☐ Eggs
- ☐ Peanuts
- ☐ Strawberries
- ☐ Gluten
- ☐ Lactose
- ☐ Soy

FAMILY HX

- ☐ Adopted/Unknown
- ☐ Noncontributory
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataract
- ☐ Blindness
- ☐ Lazy Eye (Amblyopia)
- ☐ Strabismus

****see other side****

- ☐ Color Blindness
- ☐ Retinitis Pigmentosa
- ☐ Uveitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Stroke

Family and Personal Health History Review & Inventory

PERSONAL SYSTEM REVIEW
YOUR MEDICAL HISTORY

YOUR SOCIAL HISTORY

Smoking/Tobacco

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Ever Day Smoker
- ☐ Current Some Day Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Light Tobacco Smoker
- ☐ Unknown If Ever Smoked

Marital Status

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Partner
- ☐ Unknown

Alcohol

- ☐ None
- ☐ Occasional/social
- ☐ 1-2 Drinks/day
- ☐ 3-4 Drinks/day

Driving

- ☐ Yes
- ☐ No

Living Conditions

- ☐ Lives alone
- ☐ Lives with spouse
- ☐ Lives with family
- ☐ Lives with Other
- ☐ Live with caretaker
- ☐ Lives in nursing home

Occupation

- ☐ Retired
- ☐ Unemployed
- ☐ Working
- ☐ Not Working
- ☐ Disabled
- ☐ Student
- ☐ Homemaker

Fall Risk

- ☐ Yes
- ☐ No

Constitutional

- ☐ Fever
- ☐ Weight loss
- ☐ Fatigue

HENT

- ☐ Hearing loss
- ☐ Dry Mouth
- ☐ Sinus Infections
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Ear Ache
- ☐ Jaw Claudication

Cardiovascular

- ☐ Blood Pressure Stable per Patient.
- ☐ Blood Pressure Uncontrolled per Patient
- ☐ Chest pain
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Shortness of Breath when Laying Flat
- ☐ Swelling of the Feet
- ☐ Racing Pulse

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Severe or Frequent Colds
- ☐ Difficulty Breathing

Gastrointestinal

- ☐ Jaundice or Yellow Skin
- ☐ Diarrhea
- ☐ Constipation
- ☐ Acid Reflux
- ☐ Trouble Swallowing
- ☐ Abdominal pain
- ☐ Nausea

Genitourinary

- ☐ Blood in urine
- ☐ Pain/Burning on Urination
- ☐ Dialysis
- ☐ Kidney Failure
- ☐ Kidney Problems
- ☐ Kidney Stones

Musculoskeletal

- ☐ Muscle Aches
- ☐ Joint Stiffness
- ☐ Joint pain
- ☐ Low Back Pain
- ☐ Difficult Laying Flat due to Musculoskeletal Discomfort
- ☐ Back Pain while Sleeping or Awakening

Integumentary/Skin/Breast

- ☐ Rash
- ☐ Skin Cancer
- ☐ Skin Sores
- ☐ Severe Itching
- ☐ Loss of Hair

Neurological

- ☐ Stroke
- ☐ Numbness
- ☐ Weakness
- ☐ Headaches
- ☐ Scalp Tenderness
- ☐ Seizures or Convulsions
- ☐ Fainting
- ☐ Dizziness
- ☐ Paralysis of Extremities
- ☐ Tremor

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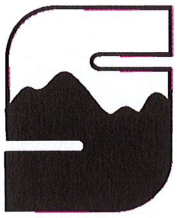

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Psychiatric

- ☐ Anxiety
- ☐ Depression

Endocrine

- ☐ Blood Sugars Stable Per Patient
- ☐ Blood Sugars Poorly Controlled Per Patient
- ☐ Patient Unsure of Glycemic Control
- ☐ Excess Thirst
- ☐ Excessive Urination
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Hair Loss
- ☐ Dry Skin

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Prolonged bleeding

Allergy/Immunology

- ☐ Autoimmune Disease
- ☐ Seasonal allergies

Please add any comments that would be helpful to know more about your health:

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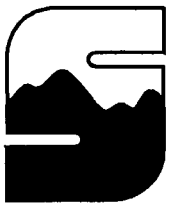

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PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN ON BACK PAGE

In consideration of receiving services from Sierra Eye Medical Group, Inc., you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. Upon check-out, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit cards: Master Card, Visa, Discovery, and American Express.

3. Your insurance policy is a contract between you and the insurance carrier. We are NOT a party to that contract. **It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Failure to provide all required information may necessitate patient payment for all charges.**

4. We will bill your insurance company once as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.

5. If your medical claim has not been paid and your insurance company has not resolved your dispute you may register a complaint with the Department of Insurance. Our office will do everything we can to assist you, however; you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

6. Any unpaid charges over 90 days old will turn to outside collection agency with additional collection agency fees. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

7. Due to large volume of cancelled appointments, there will be a minimum charge of $50.00 if the office is not notified one business day prior to the appointment date, so please contact the office during business hours of 8:00 am to 5:00 pm if you should need to cancel.

No show patients will also be charged a fee of $50.00.

See other side

If you are scheduled for any surgical procedure, please note, we require at least 72 hours (3 business days) notice to either cancel or reschedule your procedure so that we can schedule another patient in your appointment slot.

A notice of less than 72 hours (3 business days) will result in a $100 cancellation fee.

After Hours Calls:

We have a doctor on-call 24/7. If you call after hours you will be subject to a $25-$100 fee, which is not covered by your insurance.

Remember, these charges are not billable to your insurance company; this is your full responsibility.

8. Returned checks are subject to a $50.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____

Patient Signature (or parent / guardian of minor child) **Date**

Copy / Declined Copy of Patient Financial Agreement

Initials: _____

Acknowledgement of Receipt of Notice

Sierra Eye Medical Group, Inc. (SEMG) &

Sierra Ambulatory Surgery Center, A Medical Corporation (SASC)

2828-2830 W. Main St., Visalia, CA 93291-4300

Privacy Official:

Deborah Navarrette (SEMG & SASC) – Phone (559) 636-1000, Ext. 225

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

The most current Notice of Privacy Practices is on our website www.sierraeyegroup.com.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

Account # _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator o fan incompetant patient
- ☐ beneficiary or personal representative of deceased patient

Name of patient: _____

Account # _____

I authorize _____ (Relation) _____(DOB)_____

access to all my Patient Health Information (excluding): Please specify _____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgement refused:

Efforts to obtain:

_____

Reasons for refusal:

_____