STEVEN M. CANTRELL, M.D.
MATTHEW G. KIRKMAN, M.D.
WILLIAM P. GERLACH, O.D.
MICHELLE C. CANTRELL, O.D.

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

HOME PHONE______________ WORK PHONE______________ CELL PHONE ______________

❑ MALE
❑ FEMALE AGE________ BIRTH DATE______________ SOCIAL SECURITY ______________

PATIENT'S RACE______________ ETHNICITY: Hispanic or Non-Hispanic PREFERRED LANGUAGE ______________

OCCUPATION______________________________ DRIVER LIC OR ID ______________

EMAIL____

EMPLOYER NAME AND ADDRESS ____

❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED

REFERRED BY ____
DO WE HAVE YOUR PERMISSION TO THANK THE PERSON WHO REFERRED YOU? ❑ YES ❑ NO

FAMILY PHYSICIAN ____

SPOUSE'S NAME______________________ SPOUSE'S OCCUPATION ______________

EMPLOYER OF SPOUSE______________________ PHONE______________

EMPLOYER'S ADDRESS ____

IN CASE OF AN EMERGENCY:

CONTACT NAME______________________ RELATIONSHIP TO PATIENT______________

HOME PHONE NO.______________ WORK PHONE NO.______________

PERSON RESPONSIBLE FOR PAYMENT

NAME ____

INSURANCE INFORMATION

❑ MEDICARE# ______________ ❑ MEDI-CAL ❑ PRIVATE INSURANCE ❑ VISION PLAN

NAME OF COMPANY ______________________ POLICY# ______________

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 statement 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

In Case of Errors or Inquiries About Your Bill

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1. If you want to preserve your rights under the act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:

a. Do not write on the bill. On a separate sheet of paper write (you may telephone your inquiry, but **doing so will not preserve your rights under this law**) the following:

I. Your name and account number (if any).

II. A description of the error and an explanation (to the extent you can explain) why you believe it is an error.

If you only need more information, explain the item you are not sure about and, if you wish, ask for evidence of the charge such as a copy of the charge slip. Do not send in your copy of the sales slip or other document, unless you have a duplicate copy for your records.

III. The dollar amount of the suspected error.

IV. Any other information (such as your address) which you think will help the creditor to identify you or the reason for your complaint or inquiry.

b. Send your billing error notice to: (creditor's name and address).

Mail it as soon as you can, but in any case, early enough to reach the creditor within 60 days after the bill was mailed to you.

2. The creditor must acknowledge all letters pointing out possible errors within 30 days of receipt, unless the creditor is able to correct your bill during that 30 days. Within 90 days after receiving your letter, the creditor must either correct the error or explain why the creditor believes the bill was correct. Once the creditor has explained the bill, the creditor has no further obligation to you even though you still believe that there is an error, except as provided in paragraph 5 below.

3. After the creditor has been notified, neither the creditor nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount in dispute; but periodic statements may be sent to you, and the disputed amount can be applied against your credit limit. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until the creditor has answered your inquiry. **However, you remain obligated to pay the parts of your bill not in dispute.**

4. If it is determined that the creditor has made a mistake on your bill, you will not have to pay any finance charges on any disputed amount. If it turns out that the creditor has not made an error, you may have to pay finance charges on the amount in dispute, and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct, the creditor must send you a written notification of what you owe; and if it is determined that the creditor did make a mistake in billing the disputed amount, you must be given the time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged to you.

5. If the creditors explanation does not satisfy you and you notify the creditor in writing within **10** days after you receive his explanation that you still refuse to pay the disputed amount, the creditor may report you to credit bureaus and other creditors and may pursue regular collection procedures. But the creditor must also report that you think you do not owe the money, and the creditor must let you know to whom such reports were made. Once the matter has been settled between you and the creditor, the creditor must notify those to whom the creditor reported you as delinquent of the subsequent resolution.

6. If the creditor does not follow these rules, the creditor is not allowed to collect the first $50 of the disputed amount and finance charges, even if the bill turns out to be correct.

7. If you have a problem with property or services purchased with a credit card, you may have the right not to pay the remaining amount due on them, if you first try in good faith to return them or give the merchant a chance to correct the problem.

I (WE) AGREE AND UNDERSTAND:

1. That each purchase I instruct to be charged to my account is to be recorded on a sales check or such other form as the seller may use from time to time, and if accepted by the seller, it is referable to this agreement.
2. A statement will be sent to me detailing the charges, payments and credits entered on my account during the month preceding the closing date of the statement. The total amount owing at that time will be indicated by the entry new balance.
3. (a) I may pay the balance in full within 30 days of the closing day of the statement and there will be no **FINANCE CHARGE.**

   (b) If I do not pay the full amount within 30 days of the closing date of each statement, I will pay the amount due according to the payment schedule in effect from time to time. The minimum periodic payment will be $25.00 or the total balance when less than $25.00.
4. **FINANCE CHARGE** will be calculated each month on the amount of the unpaid balance (referred to as previous balance) after deducting payments or credits and before adding new purchases:

   1½% per month (**ANNUAL PERCENTAGE RATE 18%**). **MINIMUM CHARGE** $1.00 per month.

   These charges do not exceed those permitted by law, but are subject to change if permitted by law.

   I may pay the total balance due at any time without penalty or additional **FINANCE CHARGE.**
5. If monthly payments become past due I agree to pay the total amount owing upon demand and to pay reasonable collection costs, attorney fees and court costs as permitted by law if such are incurred by the seller.
6. I understand delivery of this disclosure statement does not indicate the account I (we) are applying for has been approved and that I (we) will be informed of this decision separately.

YOUR RESPONSIBILITIES

As required by Paragraph B of 1788.21 and 1788.22 of Article 3 entitled Debtor Responsibilities of California's Fair Debt Collection Practices Act, Chapter 907 of the Civil code which states:

"Each responsibility set forth in subdivision (a) of Paragraphs 1788.21 and 1788.22 shall apply only if and after the creditor clearly and conspicuously in writing discloses such responsibilities to such person."

1788.20 In connection with any request of application for consumer credit, no person shall:

(a) Request or apply for such credit at a time when such person knows there is no reasonable probability of such person's being able or such person then lacks the intention, to pay the obligation created thereby in accordance with the terms and conditions of the credit extension; or

1788.21 (a) In connection with any consumer credit existing or requested to be extended to a person, such person shall within a reasonable time notify the creditor or prospective creditor of any change in such person's name, address, or employment.

1788.22 (a) In connection with any consumer credit extended to a person under an account:

(1) No such person shall attempt to consummate any consumer credit transaction thereunder knowing that credit privileges under the account have been terminated or suspended.

(2) Each such person shall notify the creditor by telephone, telegraph, letter, or any other reasonable means that an unauthorized use of the account has occurred or may occur as the result of loss or theft of a credit card, or other instrument identifying the account, within a reasonable time after such person's discovery thereof, and shall reasonably assist the creditor in determining the facts and circumstances relating to any unauthorized use of the account.

STEVEN M. CANTRELL, M.D.
MATTHEW G. KIRKMAN, M.D.
WILLIAM P. GERLACH, O.D.
MICHELLE C. CANTRELL, O.D.

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

Name: ______________________________ **Date:** ______________

Name of your personal physician or clinic you attend: ______________________

List any drug allergies and reactions:

	Drug	*Reaction*
1)		
2)		
3)		

List your current medications (include any over the counter medicines):

	Name		*Name*
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

List any present health problems (such as high blood pressure, diabetes, or heart trouble):

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

List any major surgeries you have had:

	Surgery Type	*Year*
1)		
2)		
3)		
4)		
5)		

Family and Personal Health History Review & Inventory

PERSONAL SYSTEM REVIEW
YOUR MEDICAL HISTORY

FAMILY HISTORY (mother, father or siblings) OF HEALTH PROBLEMS LISTED BELOW

- ❒ Lazy eye (Amblyopia)
- ❒ Blindness
- ❒ Cataracts
- ❒ Crossed eyes
- ❒ Diabetic retinopathy
- ❒ Glaucoma
- ❒ Macular degeneration
- ❒ Cancer
- ❒ Diabetes
- ❒ Heart Disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Other familial disease

YOUR SOCIAL HISTORY

- ❒ Smoke ___packs/day X ___yrs
- ❒ Alcohol___drinks/day X ___yrs
  - ❒ rarely
  - ❒ only socially

- ❒ Not driving ❒ Driving
- ❒ Driving with limitations

- ❒ Live alone
- ❒ Live with spouse or companion
- ❒ Live with adult child
- ❒ Live in assisted care facility
- ❒ Live in nursing home
- ❒ Live at home with care giver

Your occupation:

____

Comments:

Constitutional
- ❒ Recent or recurrent fever?
- ❒ Recent weight loss?
- ❒ Recent weight gain?
- ❒ ______________________

Eyes
- ❒ Blurred vision?
- ❒ Double vision?
- ❒ Glare?
- ❒ ______________________

Ears, Nose, Throat
- ❒ Hearing loss?
- ❒ Sinus problems?
- ❒ ______________________

Cardiovascular
- ❒ Chest pain?
- ❒ Irregular heart beat?
- ❒ Heart failure?
- ❒ High blood pressure?
- ❒ Slow heart rate?
- ❒ Past coronary artery angioplasty?
- ❒ Past coronary artery stent(s)?
- ❒ Past open heart surgery?
- ❒ ______________________

Respiratory
- ❒ Shortness of breath?
- ❒ Wheezing?
- ❒ Asthma?
- ❒ Coughing up blood?
- ❒ ______________________

Gastrointestinal
- ❒ Abdominal pain?
- ❒ Nausea?
- ❒ History of hepatitis?
- ❒ History of stomach or colon cancer?
- ❒ ______________________

Genitourinary
- ❒ Blood in urine?
- ❒ If female: unexpected bleeding?
- ❒ ______________________

Musculoskeletal
- ❒ Joint pain?
- ❒ Low back pain?
- ❒ Arthritis?
- ❒ Gout?

- ❒ ______________________

Integumentary/Skin/Breast
- ❒ Rosacea?
- ❒ Have you had breast cancer?
- ❒ Have you had skin cancer?
- ❒ ______________________

Neurological
- ❒ Numbness?
- ❒ Weakness?
- ❒ Have you ever had a TIA?
- ❒ Have you ever had a stroke?
- ❒ Have you ever had CT scan of head?
- ❒ Have you had MRI scan of head?
- ❒ ______________________

Psychiatric
- ❒ Anxiety?
- ❒ Depression?
- ❒ ______________________

Endocrine
- ❒ Diabetes? Insulin dependent ☐ Yes ☐ No
- ❒ Thyroid problem?
- ❒ Ever consulted an endocrinologist
- ❒ ______________________

Hematologic/Lymphatic
- ❒ Anemia?
- ❒ Blood disorder?
- ❒ Unusual bleeding?
- ❒ Are you taking anticoagulants?
- ❒ ______________________

Allergic/Immunologic
- ❒ History of hives?
- ❒ Hay fever?
- ❒ Seasonal allergies?
- ❒ ______________________

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

STEVEN M. CANTRELL, M.D.
MATTHEW G. KIRKMAN, M.D.
WILLIAM P. GERLACH, O.D.
MICHELLE C. CANTRELL, O.D.

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

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.

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.

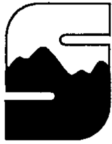
We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

____ ________________

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

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

____