

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, 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
- Authorization for Claims Payment and Reviews
- Medical History Form
- Patient Financial Agreement
- Acknowledgement of Notice of Privacy Practices (NPP)  
(To view our NPP, go to [www.sierraeye.com](http://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](http://www.sierraeye.com) and follow the links to the direction page.

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

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

(for office use only)

ACCT # \_\_\_\_\_

## REGISTRATION FOR SIERRA EYE MEDICAL GROUP, INC.

Patient's Name (Last, First, MI): \_\_\_\_\_

Patient's Home Phone Number: \_\_\_\_\_ Alternate Phone Number (cell or work) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Physician: \_\_\_\_\_

☐ Male ☐ Female Age \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security \_\_\_\_\_

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Patient's Race: \_\_\_\_\_ Ethnicity: Hispanic or Non-Hispanic (please circle) Preferred Language: \_\_\_\_\_

Occupation: \_\_\_\_\_ Driver Lic or ID: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Policy ID#: \_\_\_\_\_

Patient is Subscriber/Policy Holder: Y / N Patient is Subscriber/Policy Holder: Y / N

### INSURED INFORMATION (IF OTHER THAN PATIENT) – We will request to scan your ID and insurance card

Subscriber/ Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

His or Her Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Sierra Eye Medical Group reserves right to charge a fee of \$50.00 for any scheduled visits that are:

1. Cancelled with less than 24 hours' notice.
2. Are missed without calling to cancel (no show).

Patient / Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, 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

---

### Authorization for Claims Payment and Reviews

**1. Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Sierra Eye Medical Group, Inc. for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Sierra Eye Medical Group, Inc. for services rendered to me during the applicable periods of medical care.

**2. Unauthorized, Non-Covered, or Out of Plan Services** – I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Sierra Eye Medical Group, Inc. for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

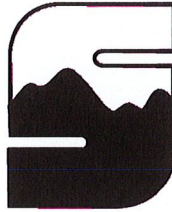
**3. For Medicare Recipients Only** – I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Sierra Eye Medical Group, Inc. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorney's fees and other collection costs incurred by Sierra Eye Medical Group, Inc. *I understand and agree this document will remain in effect for all future outpatient of physician office visits to Sierra Eye Medical Group, Inc., unless specifically rescinded in writing by me.*

Patient / Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, 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: \_\_\_\_\_

### 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 Erythematosus
- ☐ 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

## 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

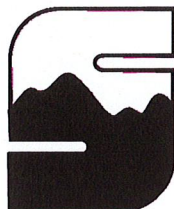
### Neurological

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

### Psychiatric

- ☐ Anxiety
- ☐ Depression

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, 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

### 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

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

### Hematologic/Lymphatic

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

### Allergy/Immunology

- ☐ Autoimmune Disease
- ☐ Seasonal allergies

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, 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-in**, we will collect your deductible and or co-pay. At checkout we will collect 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](http://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 of an incompetent 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_