STEVEN M. CANTRELL, M.D.
MATTHEW G. KIRKMAN, M.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
- 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 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.

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(for office use only)

ACCT #_____

Have you pre-registered on the portal? If you have, no need to fill out this form. Please return to front office staff.

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: _____

Primary Care Physician: _____ Location: _____

❑ 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: _____

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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 place 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: _____

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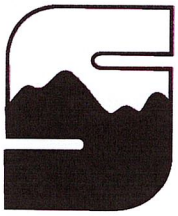

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Name: _____ **Date:** _____

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
- ☐ Uveítis
- ☐ 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 Everyday 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

In the past 7 days have you had any of the following:

Constitutional

- ☐ Fever
- ☐ Weight loss
- ☐ Fatigue

HENT

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

Cardiovascular

- ☐ Blood Pressure Stable per Patient.
- ☐ Blood Pressure Uncontrolled per Patient
- ☐ Chest pain
- ☐ Irregular Heartbeat
- ☐ 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

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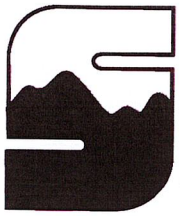

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Endocrine

- ☐ 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:

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

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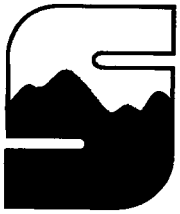

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PATIENT FINANCIAL AGREEMENT

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-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.

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:

_____