MARVIN C. MAH, O.D
Ohlone Village
1556 Washington Blvd.
Fremont, CA 9453
[510]438-0508

REGISTRATION INFORMATION

[PLEASE PRINT]

Patient _____ Age_____ Birthday _____
Last Name First Name

Sex ☐M ☐F Social Security # _____ Today's Date _____

Address _____ City _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Occupation _____ Employed by _____

Business Address _____ Email Address _____

Spouse's Name _____ Employed by _____

Business Address _____ Business Phone _____

If minor, parent's name _____ Parent's Occupation _____

Parent's Employer _____ Parent's Business Phone _____

Insurance Plan ☐VSP ☐Medicare ☐Medi-Cal ☐EyeMed ☐Other _____
[specific]

Person responsible for bill _____ Relationship to patient _____
[self, spouse, parents]

Whom may we thank for referring you to us? _____

DEDUCTIBLES AND "PATIENT EXTRAS" [VSP PATIENTS] ARE DUE AND PAYABLE BEFORE ORDERS FOR GLASSES AND/OR CONTACT LENSES ARE PLACED.

I [we] accept responsibility for any and all professional and ophthalmic fees incurred for services rendered to myself and my family. I (we) further acknowledge that vision insurance is a method of reimbursing the patient for fees paid to Dr. Marvin Mah and is not a substitute for payment. I (we) understand that payment in full is required at the time service is rendered and before materials are ordered. If this account is assigned to an accounting agency and/or an attorney, I (we) shall be responsible for the payment of collection costs, reasonable attorney's fees, and court costs.

SIGN HERE

_____ _____
Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Birth Date: _____ Last Medical Exam: _____ Last Eye Exam: _____

Medical History

Do you have any allergies to medications? ___No ___Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following you have had:

crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury

Are you pregnant and/or nursing? ____No ____Yes

Do you wear glasses? ____No ____Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ____No ____Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ____Rigid ____Soft ____Extended Wear ____Other Are they comfortable? ____No ____Yes

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	____	____	____	_____
Cataract	____	____	____	_____
Crossed Eyes	____	____	____	_____
Glaucoma	____	____	____	_____
Macular Degeneration	____	____	____	_____
Retinal Detachment/Disease	____	____	____	_____
Arthritis	____	____	____	_____
Cancer	____	____	____	_____
Diabetes	____	____	____	_____
Heart Disease	____	____	____	_____
High Blood Pressure	____	____	____	_____
Kidney Disease	____	____	____	_____
Lupus	____	____	____	_____
Thyroid Disease	____	____	____	_____
Other _____	____	____	____	_____

Social History

Do you drive? ____No ____Yes If yes, do you have visual difficulty when driving? ____No ____Yes

If yes, please describe: _____

_____

Do you use tobacco products? ____No ____Yes If yes, type/amount/how long: _____

Do you drink alcohol? ____No ____Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ____No ____Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ____Gonorrhea ____Syphilis ____HIV ____Hepatitis

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, explain and list medications)

SYSTEM	NO	YES	?	EXPLAIN/MEDICATIONS
INTEGUMENTARY(skin)	___	___	___	_____
NEUROLOGIC				
Headaches	___	___	___	_____
Migraines	___	___	___	_____
Seizures	___	___	___	_____
EYES				
Loss of Vision	___	___	___	_____
Blurred Vision	___	___	___	_____
Distorted Vision/Halos	___	___	___	_____
Loss of Side Vision	___	___	___	_____
Double Vision	___	___	___	_____
Dryness	___	___	___	_____
Mucous Discharge	___	___	___	_____
Redness	___	___	___	_____
Sandy or Gritty Feeling	___	___	___	_____
Itching	___	___	___	_____
Burning	___	___	___	_____
Foreign Body Sensation	___	___	___	_____
Excess Tearing/Watering	___	___	___	_____
Glare/Light Sensitivity	___	___	___	_____
Eye Pain or Soreness	___	___	___	_____
Chronic Infection of eye or lid	___	___	___	_____
Sties or Chalazion	___	___	___	_____
Flashes/floaters in vision	___	___	___	_____
Tired Eyes	___	___	___	_____
EARS, NOSE, MOUTH, THROAT				
Allergies	___	___	___	_____
Hay Fever	___	___	___	_____
Sinus Congestion	___	___	___	_____
Runny Nose	___	___	___	_____
Post-Nasal Drip	___	___	___	_____
Chronic Cough	___	___	___	_____
Dry Throat/Mouth	___	___	___	_____
RESPIRATORY				
Asthma	___	___	___	_____
Chronic Bronchitis	___	___	___	_____
Emphysema	___	___	___	_____
VASCULAR				
Diabetes	___	___	___	_____
Heart Pain	___	___	___	_____
High blood pressure	___	___	___	_____
Vascular disease	___	___	___	_____
GASTROINETESTINAL				
Diarrhea	___	___	___	_____
Constipation	___	___	___	_____
GENITOURINARY (genitals/kidney/bladder)	___	___	___	_____
BONES/JOINTS/MUSCLES				
Rheumatoid Arthritis	___	___	___	_____
Muscle Pain	___	___	___	_____
Joint Pain	___	___	___	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	___	___	___	_____
Bleeding problems	___	___	___	_____
ENDOCRINE (thyroid/other glands)	___	___	___	_____
PSYCHIATRIC	___	___	___	_____

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APPOINTMENT CANCELLATION POLICY

We realize that your time is as valuable to you as our time is to us. In a busy physician's office, scheduling of appointments is a high priority for the office to run smoothly. However, when patients are more than fifteen minutes late for their scheduled time, or DO NOT show for their appointments, it causes the office to run behind schedule, which does inconvenience other patients. Therefore we must employ a Cancellation Policy to protect our office time and our patients' time.

As a courtesy to you, we try our best to deliver both a reminder card and a phone call prior to your appointment, but it is ultimately your responsibility for your appointment.

Please sign below stating that you have read and understood the following policy:

1. We require 24 hours notice for all cancellations unless an unavoidable circumstance prohibits your arrival.

2. There will be a charge of $25.00 for any missed appointments.

Patient Signature: _____ SIGN HERE Date: _____

Patient Name (Print): _____

Please return this notice at your appointment time.

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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duties
We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all medical information we maintain. You may address questions regarding our privacy practices, your privacy rights, or requests for additional information to our office.

Permitted Uses and Disclosures
We may use and disclose your medical information in the ordinary course of our business. We have described some of these uses and disclosures in the following paragraphs:

- Treatment: We will provide your doctor or other health care provider with the results of the exams we perform. We may contact you before the exam to remind you of your appointment. We normally call you at the contact number you provide us. If you are not available or your voice mail answers, we will leave a brief message reminding you of the time of your appointment.
- Payment: We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health or vision care plans about payment for our services. Throughout this process, we may have to release details of your exam and medical condition if your health plan or other payer requires this information to make payment.
- Health Care Operations: We often have to use specific patient information to conduct our normal business operations. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable the doctor to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Disclosures without Authorization
We may use and disclose medical information about you, without your specific authorization, as follows:

- Disclosures Required by Law: We may be required by federal, state or local law to disclose your medical information.
- Public Health Activities: We may disclose your medical information to a public agency, such as the Food and Drug Administration (FDA) regarding drugs or medical devices.
- Victims of Abuse, Neglect, or Domestic Violence: We may be required to disclose your medical information if we feel you have been abused or neglected.
- Health Oversight Activities: We may be required to disclose your medical information to Medicare or a related agency if they select your case for a medical review.
- Judicial and Administrative Proceedings: We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal.
- Law Enforcement: We may have to disclose your medical information in conjunction with a criminal investigation by a federal or state law enforcement agency.
- Serious Threats to Health or Safety: We may be required to disclose your medical information, if, in our opinion, doing so will avert a serious threat to the public.
- Military Personnel: We may disclose your medical information to the appropriate command authorities.
- Worker's Compensation: We may disclose your medical information to comply with law regarding worker's compensation.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Patient Rights
You have certain rights with respect to your medical information.
Requesting Restrictions: You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit our use or disclosure, and 4) state to whom the restriction applies. You may revoke your restriction at any time by contacting Dr. Mah at the address shown at the beginning of this notice.
Confidential Communications: You may ask that we communicate with you in a particular way or at a certain location to maintain your confidentiality. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to Dr. Mah at the address shown at the beginning of this notice.

Inspect and Copy: You may request access to inspect and copy your medical information maintained in our records, including medical and billing records. Your request must be in writing. You will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we must deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Dr. Mah at the address shown at the beginning of this notice.

Amendment: You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information. You also have the option of submitting your own amendment. This amendment must be in writing. We will then include this amendment when we release the records in question.

Accounting of Disclosures: You may request a list of non-routine disclosures that we have made of your medical information over the previous six (6) years. This does not include disclosures we make for your treatment, to seek payment for our services, or for our normal business operations as noted in the section on permitted uses and disclosures, or for those you authorize in writing. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12 month period is free, but we may charge for additional lists within the same 12 month period.

File a Complaint: If you believe that we have violated your privacy rights, you may file a complaint directly with Dr. Mah, the Secretary of the Department of Health and Human Services, or Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Dr. Mah at the address shown at the beginning of this notice.

Patient Authorizations for Certain Disclosures
We will request your written authorization for uses and disclosures of your medical information that we did not identify in this notice or for those not otherwise permitted by law. These disclosures include your requests to provide exam results to your attorney, for exams related to life insurance or disability insurance applications, or for pre-employment physicals, among others. You may revoke your authorization in writing at any time by contacting our office. You may demand a copy of your authorization at any time.

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VOLUNTARY CONSENT FORM

Consent to use or disclose health information for treatment, payment, and health care operations.

Patient Name: _____

Patient Home Number: _____ Patient Cell Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

We have a comprehensive ***Notice of Privacy Practices*** that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this ***Consent Form***. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____