

DANIEL C. KLINE, MD, INC
3500 BARRANCA PARKWAY, STE 290
IRVINE, CA 92606

ACCOUNT NUMBER

DATE: / /

PATIENT INFORMATION

LAST NAME		FIRST NAME		M.I.	HOME PHONE	
ADDRESS				SEX	MARITAL STATUS	AGE
				M-F	M S W D	
CITY, STATE		ZIP		DATE OF BIRTH		
				/ /		
PATIENT'S EMPLOYMENT NAME/ADDRESS		WORK PHONE NUMBER		SOCIAL SECURITY		
		OCCUPATION		DRIVER'S LICENSE		

SPOUSE	OCCUPATION
SPOUSE'S BUS. ADDR/NAME	PHONE NUMBER
REFERRED BY (DOCTOR)	PHONE NUMBER

PERSONAL INSURANCE INFORMATION (MUST BE COMPLETED FOR BILLING)

<u>PRIMARY INSURANCE COMPANY</u>	SUBSCRIBER
ADDRESS	CERTIFICATE #
CITY, ST., ZIP	GROUP # OR NAME
PHONE NUMBER ()	RELATIONSHIP
<u>SECONDARY INSURANCE COMPANY</u>	SUBSCRIBER
ADDRESS	CERTIFICATE #
CITY, ST., ZIP	GROUP # OR NAME
PHONE NUMBER ()	RELATIONSHIP

NAME OF NEAREST RELATIVE OR FRIEND - NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

I hereby authorize the above named doctor to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. On balances not paid within 90 days, I will be responsible for interest and penalties incurred at 7% A \$35 cancellation fee will be issued for no-shows and cancellations less than 24 hours in advance. A service charge of \$25 will be issued for returned checks.

Patient's signature _____

PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

Telephone (Home): _____ Telephone (Work/cell): _____

Social Security: _____ Date of Birth: _____

Occupation: _____ Employer Name/Address: _____

Emergency Contact (name): _____ Em. Contact (number): _____

Date of last eye exam: _____ Dilated: Yes / No (circle one) Today's Date: _____

MEDICAL INFORMATION

What is your general health? _____

Do **you** have problems with any of these systems? (Please circle all that apply)

Gastrointestinal Y/N	Nervous Y/N	Eyes Y/N	Mental Y/N	Ear/Nose/Throat Y/N	Genitourinary Y/N
-------------------------	----------------	-------------	---------------	------------------------	----------------------

Endocrine(glands) Y/N	Cardiovascular Y/N	Musculoskeletal Y/N	Blood/Lymph Y/N	Respiratory Y/N	Skin Y/N
--------------------------	-----------------------	------------------------	--------------------	--------------------	-------------

Allergic/Immunologic: Y/N

Please explain any Yes answers above: _____

Please answer all that apply: Diabetes: Y/N Type: _____ Date of Diagnosis: _____

Allergies? Y/N To What? _____ What happens? _____

Medication Allergies? Y/N What Medicine? _____ What happens? _____

Current Medications: _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use? Y/N	Cigarettes Y/N	Tobacco Y/N	Alcohol Y/N	Other Substances? Y/N	What: _____
--------------------	-------------------	----------------	----------------	--------------------------	----------------

Name of Family Doctor: _____ Date of last visit: _____

Date of last tetanus shot: _____ Headaches: Y/N

FAMILY HISTORY

High Blood Pressure: Y/N Who? _____	Macular Degeneration: Y/N Who? _____	Diabetes: Y/N Who? _____	Cataracts: Y/N Who? _____
--	---	-----------------------------	------------------------------

Retinal Detachment: Y/N Who? _____	Glaucoma: Y/N Who? _____	Other Eye Conditions: Y/N Type: _____
---------------------------------------	-----------------------------	--

PERSONAL EYE INFORMATION (pertaining to YOUR EYES only)

Operations: Y/N Type: _____ Date: _____ Injury: Y/N Type: _____ Date: _____

Glaucoma: Y/N Cataracts: Y/N Dry Eye: Y/N Macular Degeneration: Y/N

Other Eye Problems: Y/N Type: _____

Do you wear: Eye Glasses? Y/N Contact Lenses? Y/N Type: _____

Whom may we thank for your referral: _____

Would you like to learn more about any of the following: (Mark all that apply)

LASIK _____ **BOTOX** _____ **LATISSE** _____

DANIEL C. KLINE, M.D., INC.
3500 BARRANCA PKWY, STE 290
IRVINE, CALIFORNIA 92606
TEL: (949) 653-9500
FAX: (949) 653-9513

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City/State: _____ Zip: _____

RELEASE MY MEDICAL RECORDS FROM:

Name of Doctor or Medical Group: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

TO

DANIEL C. KLINE, M.D., INC.

Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, consultation reports, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient Signature: _____ Date: _____

DANIEL C. KLINE, M.D., INC.

3500 BARRANCA PKWY, STE 290

IRVINE, CALIFORNIA 92606

TEL: (949) 653-9500

FAX: (949) 653-9513

Advance Beneficiary Notice

Patient Name: _____

The Patient or the Patient's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Patient have not been approved for payment under the Patient's health benefit program. Accordingly, the undersigned agrees that the Patient or Patient's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

PAYMENT FOR THE BELOW IS DUE AT THE TIME OF SERVICE.

Refraction (Prescription for glasses) = \$75.00

Signature of Patient or Patient's legal representative

Date

DANIEL C. KLINE, M.D., INC.
3500 BARRANCA PKWY, STE 290
IRVINE, CALIFORNIA 92606
TEL: (949) 653-9500
FAX: (949) 653-9513

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

Treatment Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your identifiable health information in order to write a prescription for you, or we might disclose your identifiable health information to a pharmacy when we call and order a prescription for you. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children, or parents.

Payment Our practice may use and disclose your identifiable health information, as needed, in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

Health Care Operations Our practice may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice. We may use your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect, Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; Workers Compensation; inmates; required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of House and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures These will be made only with your consent and with authorization of opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

Confidential Communication You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspection and Copies You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Our practices may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

Amendment You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures All of our patients have the right to request an accounting of disclosure. An accounting of disclosure is a list of certain disclosures our practice has made of your identifiable health information. All requests for an accounting of disclosure must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice You are entitled to receive a paper copy of our notice of privacy practices.

Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you have any questions, requests or complaints regarding this notice of our health information privacy policies, please discuss with the doctor.

We are required by law to maintain the privacy of individuals and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information

By signing this form, you consent to our use and disclosure of protected information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Print Name: _____ Signature: _____ Date: _____