

**CALIFORNIA ORBITAL CONSULTANTS: Madhu R. Agarwal, M.D**

**PATIENT REGISTRATION INFORMATION: PLEASE COMPLETE ALL SECTIONS**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex: M F  
Birth date: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_ Driver License #: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Patient's Employer: \_\_\_\_\_  
Occupation/Title: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
For appointment reminders or call back request or information regarding your health, OK to leave messages on answering machine or text? Yes \_\_\_ No \_\_\_  
Is it OK to leave messages with family members? Yes \_\_\_ No \_\_\_

**SPOUSE/PARENT INFORMATION**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Soc. Sec #: \_\_\_\_\_ Sex: M F  
Address if different than above: \_\_\_\_\_  
Home Telephone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

**PLEASE LIST ALL THE DOCTORS WHO CARE FOR YOU**

Provider's Name: \_\_\_\_\_ Specialty \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_  
Provider's Name: \_\_\_\_\_ Specialty \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_  
Provider's Name: \_\_\_\_\_ Specialty \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_  
Provider's Name: \_\_\_\_\_ Specialty \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_

**Allergies To Medication:**  
\_\_\_\_\_

**Past Surgeries:**  
\_\_\_\_\_

**Medical Problems:** Diabetes \_\_\_ High Blood Pressure \_\_\_ Cholesterol \_\_\_ Cancer \_\_\_ Head Trauma \_\_\_

**PLEASE LIST OTHER MEDICAL PROBLEMS BELOW:** \_\_\_\_\_

**FAMILY HISTORY:** \_\_\_\_\_

**Marital Status:** Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_  
Do you smoke? Yes \_\_\_ No \_\_\_  
Do you drink alcohol? Yes \_\_\_ No \_\_\_

I hereby grant permission to California Orbital Consultants to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to California Orbital Consultants.

\_\_\_\_\_  
Signature of Patient (Parent if Patient is minor) \_\_\_\_\_  
Date

**FINANCIAL POLICIES**

Copayment and deductible payments as determined by your agreement with your insurance carrier are **due at the time of service**. We will file your insurance claim if you agree to have your insurance company pay the doctor directly for services provided. Not all insurance plans cover all services; in the event your insurance plan determines a service to be "not covered", you will be responsible for payment. Payment is due upon receipt of a statement from our office.

If you have no health insurance, payment is due at the time of service. There will be a \$25 fee for returned checks.

In fairness to other patients and the physician, we request a 24-hour notice to cancel an appointment. You may be charged \$25 for a missed appointment. Missing more than two appointments without providing notice are grounds for discharge from the practice.

**I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release information necessary to secure the payment of benefits from my insurance company.**

CREDIT CARD AUTHORIZATION: I acknowledge and authorize California Orbital Consultants to charge my credit card on file for any co-payment, co-insurance, deductible and/or charges not covered by health insurance provider. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account with the office.

**REFERRAL REQUIREMENT**

I am seeking treatment from California Orbital Consultants and understand that *if* my medical insurance company requires a referral to see a specialist, I am responsible for ensuring that the referral has taken place. If I have not obtained a required referral at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by my insurance company.

**NOTICE OF PRIVACY PRACTICES**

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPAA")**, I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I have been informed by California Orbital Consultants of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

**INFORMATION ABOUT DILATING YOUR EYES**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and agree to the above policies:

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Signature

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Print Name

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Date