WELCOME TO CALIFORNIA VISION CENTER

NAME (LAST)_____, (FIRST)_____ M / F AGE ____DOB ____/____/____

CELL # (____)_____HOME # (____)_____EMAIL _____

HOME ADDRESS _____CITY _____ STATE ____ ZIP _____

SSN # _____DRIVER'S LICENSE # _____

OCCUPATION _____ EMPLOYER _____

NAME OF LEGAL GUARDIAN IF MINOR _____GUARDIAN'S DRIVER'S LICENSE # _____

IF YOU'RE A NEW PATIENT, WHO MAY WE THANK FOR YOUR REFERRAL? (PLEASE CIRCLE ONE)

INSURANCE / FRIEND / FAMILY / WALK-BY / DOCTOR / VERIZON / CLARK / YELLOW PAGES / OTHER_____

MEDICAL CONDITIONS (please check all that apply)

☐DIABETES (☐type 1 ☐type 2 ☐pre) ☐HIGH BLOOD PRESSURE ☐HIGH CHOLESTEROL ☐ALLERGIES

OTHER: _____ _____ _____ **Allergic to meds:** _____

Please list medications that you take:

Please check all the symptoms that you experience:

☐Blur at distance ☐Blur at near ☐Strain w/ computer ☐Sensitive to light ☐Headache ☐ Eyes water ☐Eyes itch ☐Eyes burn

REASON FOR THIS EXAM: CHECK-UP / GLASSES / CONTACTS / EYE DISEASE / DIABETES / _____

DO YOU WEAR GLASSES? YES / NO. DO YOU WEAR CONTACTS? YES / NO. WHAT TYPE? _____

ARE YOU INTERESTED IN CORRECTIVE LASER EYE SURGERY? YES / NO.

FAMILY HISTORY OF EYE DISEASE? (WHAT AND WHO) _____

FAMILY HISTORY OF MEDICAL CONDITIONS? (WHAT AND WHO) _____

VISION INSURANCE NAME	INSURED NAME	INSURED BIRTHDATE	POLICY# OR SS#	RELATION TO PATIENT

MEDICAL INSURANCE NAME	INSURED NAME	INSURED BIRTHDATE	POLICY# OR SS#	RELATION TO PATIENT

I the undersigned have insurance coverage which I assign directly to Dr. Jana Chen all medical benefits, if any, otherwise payable to me for services rendered. I understand I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

SIGNATURE _____**(GUARDIAN IF MINOR) DATE** _____

(Please reserve the signature space below for future visits. If the above information remains unchanged, please initial and date below.)

SIGN _____ **DATE** _____ **/ SIGN** _____ **DATE** _____

SIGN _____ **DATE** _____ **/ SIGN** _____ **DATE** _____

** ***PLEASE READ AND SIGN THE BACK*** **

STORE POLICY

1. ALL SALES ARE FINAL.
2. Refunds/Exchanges for glasses: We do not offer refunds or exchanges on glasses. However, we will gladly re-make any lenses with prescription problems within **30 days** of purchase.
3. Refunds/Exchanges for contacts: We do not offer refunds on contacts. Exchanges with another brand or prescription are allowed within **14 days** of purchase. The boxes must be unopened, unmarked and unused in any way.
4. Contac lens fitting: The initial fitting fee includes any follow-up visits within 30 days. Additional $25 fee will be charged for every office visit afterwards. All contact lens fitting must be done within 30 days of the eye exam.
5. Progressives: If you cannot adapt to progressive lenses, we will gladly remake them to bifocal or single vision lenses free of charge. However, the difference in price will not be refunded.
6. Patient's Own Frame: The lab needs to heat and bend the frame to fit the lenses. An old frame may not sustain such manipulation and may lead to breakage or damage. We are not responsible for such breakage or damage.
7. Responsibility of Payment: Because our glasses are made specifically with your prescription, we cannot sell your glasses to another patient. Therefore, you are responsible for the full payment of your glasses even if you decide not to pick them up. Such payment is due within 30 days from the purchase date. All unpaid balance will be sent to collection.
8. Failure of Payment: Patients are responsible for all collection fees, court costs and attorney fees to collect unpaid accounts. There is a **$25** fee for each bounced check.

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. THIS NOTICE IS EFFECTIVE 12/12/02 UNTIL FURTHER NOTICE.

Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA). Dr. Jana Chen, Dr. James P. Cheung & Associates can use your protected health information for treatment, payment, and health care operations.

a.) Treatment – We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

b.) Payment – We may use and disclose your health information to obtain payment for services we provide you.

c.) Health Care Operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use your health information for marketing communications without your written authorization.

Require By Law

We also may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminder

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

-You have the right to receive confidential communications regarding your protected health information.
-You have the right to inspect and copy your protected health information.
-You have the right to amend your protected health information.
-You have the right to receive an account of disclosures of your protected health information.
-You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Dr. Jana Chen, Dr. James Cheung & Associates are required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted or are available within our office.

Complaints

If you have complaint regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information

For further information about Dr. Jana Chen, Dr. James Cheung & Associates privacy policies, please contact the doctor at 4143 Riverside Dr # C Chino, CA 91710 (909) 591-5438

By signing below, I acknowledge I have read and understood all of the above.

Patient Signature _____ Date _____