South Bay Retina, Inc.
Vitreo-retinal Diseases & Surgery
Phone: 408.294.3534
Fax: 408.294.3214

Keshav Narain, M.D.
455 O'Connor Drive #310, San Jose 95128
9360 No Name Uno Road #210, Gilroy 95020
info@southbayretina.com

NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____

Birth date: _____/_____/_____ Sex: Male / Female Social Security #: _____-_____-_____

Address: _____ Apt: _____ City: _____ Zip: _____

☐ Primary Phone: (_____) _____ ☐ E-mail: _____

Primary Medical Doctor: _____ **Referring Physician**: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____

Insurance POLICY HOLDER:

If you are listed as a dependent on your insurance policy, please provide the subscriber's information:

Subscriber's / Guarantor's Name: _____

Date of Birth: _____/_____/_____ Relationship: _____

PHARMACY INFORMATION:

Pharmacy: _____ Address: _____

INSURANCE AUTHORIZATION

I hereby authorize the South Bay Retina, Inc. to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments.

INFORMATION REGARDING DILATING EYE DROPS

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. For Dr. Narain to properly examine the retina, your eyes must be dilated. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. To make your visit more comfortable, sunglasses are available at the front desk at any time.

It is not possible for your ophthalmologist to predict how much your vision will be affected. If you feel that driving may be difficult for you immediately after an examination, it's best if you make arrangements not to drive yourself. Your eyes may remain dilated for approximately 4 to 6 hours. An 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 hereby authorize Dr. Keshav Narain and/or such assistants, as may be designated by him, to administer dilating eye drops. I understand that the eye drops are necessary to diagnose my condition.

My signature below indicates that I have read, understood, and consent to the above polices regarding insurance authorization and dilating eye drops.

Signature: _____ **Date:** _____

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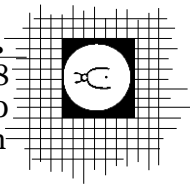

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize South Bay Retina, Inc. to access my medication history as is required to process, retrieve or transmit electronic prescriptions.

Signature: _____ **Date:** _____

PROTECTED HEALTH INFORMATION (HIPAA)

I consent to the use and disclosure of my protected health information by South Bay Retina, Inc., Keshav Narain, M.D. and staff for the purposes of treatment, payment and health care operations only.

I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information and other information used in whole or in part, to make decisions about me. I understand that information about how my protected health information may be used, along with the complete Notice of Privacy Practices is available and that I may request a copy at any time.

I understand that all information is used in the care and treatment of my condition. No information, medical or otherwise shall be used for commercial purposes or released to any party for purposes other than my healthcare. In addition, I also authorize the release of my information to the individuals listed on this page.

Signature: _____ **Date:** _____

**Complete this section only when someone other than the patient is signing on their behalf.

Patient's relationship to signer: _____

- ❑ Patient is unable to sign or acknowledge
- ❑ Patient refuses to sign but was given the opportunity to acknowledge and sign

Signature: _____ **Date:** _____

Please list family members and individuals who are involved in your care that we are authorized to share your health information with:

_____

_____

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing South Bay Retina, Inc. and Dr. Keshav Narain as your health care provider. We are committed to providing quality care service to all our patients. The following is a statement of our financial policy, which we require that you read and understand prior to any treatment or services.

Insurance Benefits: You are responsible for knowing your insurance benefits, including whether Dr. Keshav Narain is a contracted provider with your insurance company, your covered benefits and any such exclusions, and any pre-authorization requirements. It is not the responsibility of Dr. Keshav Narain or South Bay Retina, Inc. to know your insurance coverage.

Insurance Information: You are responsible for making sure South Bay Retina, Inc. has up-to-date and accurate insurance information on file, including current insurance cards and/or changes in insurance policies. Failure to provide this information may result in charges being billed to you. Our staff ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments, and Coinsurance: It is your responsibility to know if your insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, or any other type of benefit limitation for the services you receive. You understand it is your responsibility to cover any additional charges as stated by your insurance policy or plan.

Physician Referrals: It is your responsibility to know if Dr. Keshav Narain is a contracted in-network provider recognized by your insurance company or plan or it may result in claims being denied or higher out of pocket expenses to you. It is also your responsibility to know if your primary care provider's (PCP) referral requests have been processed by your insurance company or plan. If claims are denied because the physician was not authorized, you will be responsible for full payment(s).

Self-Pay: If you do not have health insurance, are with an insurance plan that South Bay Retina, Inc. is not contracted with, or you are unable to verify your coverage on the date of service, South Bay Retina, Inc. will collect an estimated payment at the time of service. There may be addition charges depending on the services provided for which you may be billed for later. You understand and agree to pay for these services accordingly.

Financial Responsibility: You assume financial responsibility and will make full payment(s) if your insurance company denies coverage and/or payment for services provided, including but not limited to diagnostic testing which may be not be considered medically necessary to your insurance plan. We will do our best to verify coverage but it ultimately your responsibility to know your benefits prior to being seen.

I hereby authorize payment of medical benefits directly to South Bay Retina, Inc. for services rendered. Authorization is hereby granted of my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

I have read and consent to the financial policies contained above. My signature below serves as acknowledgement of a clear understanding of my financial responsibility.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Keshav Narain, MD | South Bay Retina, Inc

Please complete all sections, then sign and date at the bottom

SYMPTOMS

Place a mark in the box next to the symptom to indicate that you have any of the following:

EYES / VISION

	Which eye?		*Which eye?*		*Which eye?*		*Which eye?*
☐ Blurred Vision	_____	☐ No Vision	_____	☐ Pain	_____	☐ Itching	_____
☐ Distortion	_____	☐ Curtain	_____	☐ Watering	_____	☐ Redness	_____
☐ Shadow	_____	☐ Flashes	_____	☐ Light sensitive	_____	☐ Dryness	_____
☐ Dark Spot	_____	☐ Floaters	_____	☐ Double Vision	_____	☐ **NONE**	

SYSTEMIC

☐ Shortness of Breath	☐ Dizziness	☐ Joint Pain	☐ Anxiety
☐ Numbness / Paralysis	☐ Chest Pain	☐ Hearing Loss	☐ Muscle Tenderness
☐ Headaches / Migraines	☐ Chills	☐ Cough / Wheezing	☐ Weight Change
☐ Diarrhea / Constipation	☐ Nausea / Vomiting	☐ Other: _____	☐ **NONE**

MEDICAL / FAMILY HISTORY

Place a mark in the box under "self" to indicate that you have any of the following conditions, mark "family" if someone in your family does and indicate who in the space provided:

EYES / VISION

Self	**Family**	**Self**	*Which eye?*	
☐ Blindness	☐ _____	☐ Eye Injury	_____	☐ **NONE**
☐ Retinal Detachment	☐ _____	☐ Eye Infection	_____	
☐ Macular Degeneration	☐ _____	☐ Cataract Surgery	_____	
☐ Glaucoma	☐ _____	☐ Other Eye Surgery	_____	

GENERAL HEALTH

Self	**Family**	**Self**	**Family**	**Self**
☐ Heart Condition	☐ _____	☐ Thyroid	☐ _____	☐ Tuberculosis
☐ High Blood Pressure	☐ _____	☐ Arthritis	☐ _____	☐ HIV
☐ Vascular Disease	☐ _____	☐ Asthma	☐ _____	☐ Hepatitis (Type ____)
☐ Stroke	☐ _____	☐ Emphysema	☐ _____	☐ Pacemaker
☐ High Cholesterol	☐ _____	☐ Cancer	☐ _____	☐ Alcohol Use
☐ Kidney Disease	☐ _____	☐ Lupus	☐ _____	☐ Other: _____
☐ Diabetes	☐ _____	☐ Skin Condition	☐ _____	☐ **NONE**
☐ Dialysis – How often? _____		**Do you smoke?**	☐ Yes ☐ No	☐ Discontinued: _____

Please list any **ALLERGIES** to medications or other substances: _____ ☐ **NONE KNOWN**

Please list **ANY MEDICATIONS** you are taking _____

☐ **NONE** _____

Please list any **surgical** procedures you have undergone: _____

☐ **NONE** _____

Primary reason you are here today? _____

The information that I have provided is current and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____