Dr. Melanya Garibyan
149 South Glenoaks Blvd.
Burbank, CA 91502
VERS062021

PATIENT INFORMATION

PLEASE FILL OUT ALL **4 PAGES** AND PRESENT TO FRONT DESK WITH **YOUR ID AND ALL INSURANCE CARDS**

PATIENT'S NAME_________ ____M or F or Other TODAY'S DATE ____/____/_____
LAST FIRST

SS# _____-_________-_________ ID/DRIVER'S LICENSE #___________________BIRTHDATE____/____/______AGE______

ADDRESS____
NUMBER STREET CITY STATE ZIP CODE

HM PHONE (_____)_______-_________CELL PHONE(______)_________-_______WORK PHONE(______) _______-_______

EMAIL: ______________________________ Do you consent to communication via Email? Yes/No Text message Yes/No

OCCUPATION: __________________________________ EMPLOYER: _____________________________________

EMERGENCY CONTACT: ____
NAME RELATIONSHIP TO PATIENT DAYTIME PHONE

WHOM MAY WE THANK FOR REFERRING YOU? ____

VISION PLAN - CASH PAY / VSP / EYEMED / MES ___________________
ID/ GROUP # _________________________ PHONE# ____________________

HEALTH INSURANCE - CASH PAY / PPO (BLUE CROSS / BLUE SHIELD / AETNA /CIGNA /UHC/Anthem) Medicare
Other _____________ ID/GROUP#_____________________________ PHONE # _____________________

HMO (*Please note we do not accept HMOs for medical issues- you will be charged privately if you have an HMO)

PRIMARY INSURED NAME (if not patient) ____

INSURED'S SS# :(if not patient)_______-________-_____________**INSURED'S BIRTHDATE** (if not patient): ____/_____/__

-I understand that my insurance plan listed above may have an unmet deductible and/or copayments and may not fully pay for my services today. I understand that Dr. Garibyan utilizes services to calculate my portion owed and will bill my insurance company on my behalf but I agree that I am ultimately liable for any charges not covered by my insurance company.
I agree to pay all charges upon 30 days of receiving a bill from Dr. Garibyan

-I understand that it is my responsibility to cancel my appointment 24 hours or more in advance of scheduled appointment if you are unable to make it. By signing this form, I acknowledge that if I do not cancel any appointment on time, I will be charged $25 fee.

-I understand that all professional service fees, co-insurances, co-payments are due at the time of services and are fully non-refundable

-I understand that due to the highly personalized nature of eye-care and eye-wear, ALL ORDERS AND SALES ARE FINAL. Once order is processed it cannot be canceled. No refunds will be issued. Any changes may be subject to a service fee.

**________________________________ ______________________________
Patient/ Responsible Party Signature Date

If signing for minor or adult patient, what is your relationship to patient?

________________________________ ______________________________
Relationship to Patient Print Name

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Receipt of Notice of Privacy Policies & Consent Form/HIPPA

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.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this 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 services 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 healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare 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.

**______________________________ ______________________________

Patient/ Responsible Party Signature Date

If signing for minor patient, what is your relationship to patient? If signing for an adult, what is the source of your authority to sign?

______________________________ ______________________________

Relationship to Patient Print Name

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PATIENT RETINAL CHECK CONSENT

An important part of your routine checkup is a proper and full check the health of the back of your eyes-your retinas.

To do this, please CHOOSE ONE of the methods below

☐ I choose to have **the Optomap Wideangle Digital Retinal Imaging** of my retina.
I understand that I will have a charge **of $39.00** due today
I understand that **I will NOT have blurry vision** after this procedure. I will not have dilating drops put in.
I attest that **I do NOT have seizure disorders**

OR

☐ I choose **TO BE DILATED today** with drops - this is typically covered within your comprehensive exam
(Note: If you choose to RETURN to have this done on another day there is a $39.00 charge on return dilation)
If you are pregnant, we will not dilate you today. You must either do the imaging or return on another day after the pregnancy (there will be a $39.00 charge on return dilation)

I understand that dilating drops are used to dilate or enlarge the pupils of the eyes to allow Dr. Garibyan to get a better view of the inside of your eye.

I understand that dilating drops WILL CAUSE BLURRY VISION FOR 2 TO 4 HOURS and will make bright light bothersome. It is not possible to predict exactly how much your vision will be affected. Dr. Garibyan recommends you avoid driving, avoid operating machinery, and wear sunglasses when outside until the effects wear off.

If you do not have sunglasses with you, please ask us to provide you with temporary disposable ones.

Rarely adverse reaction, such as allergic reaction or 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. Melanya Garibyan and/or such assistants as may be designated by her to administer dilating eye drops.

______________________________	****______________________	__________
Patient's Name	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.

____________________	____________________________
Relationship to Patient	Print Name

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PATIENT HEALTH HISTORY

When was your last eye exam? _______ last dilation exam? __________By which doctor/office?_________________

Do you currently wear any glasses? Y / N Do you currently wear contact lenses? Y / N
If yes, for far, close, or both? _____________What brand? Power? ___________________How often you toss? _____

Have you had any eye injury? Eye surgery, or been diagnosed with an eye disease? Y / N
If yes, what? When? Which eye? ____

Have you experienced any of the following symptoms/visual issues in the last year?
Floaters Flashes Double vision Eye Turn Loss of vision Blur (Near? Far?)
Burning Itching Tearing Eyelid Twitching Other: _______________________

What is the main purpose of your visit today?____

When was your last medical exam? _____________
Name of Family Dr. _________________________________Phone number ______________________________
Name of **pharmacy** you want Rx sent to _____________________City_________Phone ___________________

Do you have any of the following conditions? Y/N If yes, circle which.
Seasonal Allergies High Blood Pressure Heart disease Respiratory HIV
Cholesterol Frequent Headaches Thyroid Arthritis Psychological
Neurological Ear/Nose/Throat Gastrointestinal Diabetes (since what year?_________)
Skin Other: ____
Current Medications: ____
____
Current Eye Drops________________________________ Allergies to: ______________________________

Do you use tobacco? Y / N Do you use alcohol? Y / N other substances Y / N

Indicate which family members have the following conditions? Circle which and indicate who or circle NONE (Limited to mom, dad, sister, brother, son, daughter)

Diabetes ________ High Blood Pressure_______ Macular Degen.______ Glaucoma ______________
Eye Turn ________ Retinal Detachment _______ Keratoconus _________ Other: __________________

Reviewed by Dr. ______