Dr. Melanya Garibyan
149 South Glenoaks Blvd.
Burbank, CA 91502
VERS10/2015

PATIENT INFORMATION

updated no change on ______
updated no change on ______
updated no change on ______

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

PATIENT'S NAME____ M F 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: ___________________________________PREFER TO COMMUNICATE VIA: HOME CELL WORK EMAIL

OCCUPATION: __________________________________ EMPLOYER: _____________________________________

EMERGENCY CONTACT: ____
NAME RELATIONSHIP TO PATIENT DAYTIME PHONE
WHOM MAY WE THANK FOR REFERRING YOU? ____

VISION INSURANCE - CASH PAY/ VSP Medical / March Vision / VSP / EYEMED / DAVIS / MES / ENVOLVE
OPTUM / TRIWEST/ Medicare (NOTE: we do NOT accept HMO Medicare plans)/ OTHER__________________________
ID/ GROUP # _________________________ ISSUE DATE (IF M-CAL) ________________ PHONE# ___________________

HEALTH INSURANCE - CASH PAY/ VSP PRIMARY CARE / BLUE CROSS/ BLUE SHIELD/ AETNA/CIGNA/UHC
Medicare (NOTE: we do NOT accept HMO Medicare plans OTHER.____
ID/GROUP#_____________________________ISSUE DATE (IF M-CAL) ______________PHONE # _____________________
PPO OR HMO (*Please note we do not accept HMOs for your medical visits, you will be charged privately if you have 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 will bill my insurance company on my behalf but I agree that I am 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.

_________________________________ ______________________________
Patient/ Responsible Party Signature Date

If signing as a responsible authority of the patient, describe the relationship to the patient and the source of authority to sign this.

__________________________________ ______________________________
Relationship to Patient Print Name

NOTE: DUE TO THE PERSONAL AND UNIQUE NATURE OF VISION CORRECTION AND CARE PRODUCTS, ALL SALES ARE FINAL!

Dr. Melanya Garibyan
149 South Glenoaks Blvd.
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(818)848-3000 (818)848-7299 fax

PATIENT NOTICES

Receipt of Notice of Privacy Policies & Consent Form

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'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 Signature

Appointment Cancellation Policy

Effective November 1.2009, we will require 24 hours notice when cancelling an appointment. It is the Patient's responsibility to call and cancel their appointment. There will be a charge of $25.00 for missed appointments that are not canceled before 24 hours of the scheduled appointment time that you have taken if you are not able to keep it. Thank you!

Comensando Novembre 1, 2009, necesitamos que nos llamen para cancelar su sita 24 horas antes. Es la responsabilidad del paciente de cancelar la cita. Hay un cargo de $25.00 dolared por no cancelar 24 horas antes de su cita . Por favor ayudenos a mantener nuestro horario I ayudar a las personas que necesitan la cita. Muchas gracias!

By signings this form you acknowledge the responsibility to cancel your appointment on time to avoid unnecessary charges.

__________________________ ________________________ __________
Patient's Name Signature Date

Dr. Melanya Garibyan
149 South Glenoaks Blvd.
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(818)848-3000 phone
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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.
Dr. Garibyan needs to do one of the following today.

______ I chose to have **the Optomap 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 do NOT have seizure disorders

OR

______ I chose **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 4 TO 8 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 (or person authorized to sign for patient) ____ **Date** ________
Dr. Garibyan ____ **Date**_________

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PATIENT HEALTH HISTORY

When was your last eye exam? _______last dilation exam?____________? By what doctor/office?_________________

Do you currently wear any glasses? Y / N
If yes, for far, close, or both? ____________________

Do you currently wear contact lenses? Y / N
If yes, what brand? Power? ____________________________

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 _____________________________________

Do you have any of the following conditions? Y/N If yes, circle which.

Allergies	High Blood Pressure	Heart disease	Respiratory	HIV
Cholesterol	Frequent Headaches	Thyroid	Arthritis	Psychological
Neurological	Ear/Nose/Throat	Gastrointestinal	Diabetes (how long? ___________)	
Skin	Other :____			

Current Medications: ____
Allergies: ____

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

Do you have any family members with the following conditions? Y / N If yes, circle which and indicate who.

Diabetes ______	High Blood Pressure_______	Macular Degen.______	Glaucoma _______________
Eye Turn _______	Retinal Detachment _______	Keratoconus _________	Other: _________________

Reviewed by Dr. _____
_____
_____