Welcome to the office of JillAnne W. McCarty, MD, PhD. We are looking forward to meeting you.

For your convenience, attached are forms for you to fill out and bring to your visit. Information on our general office policies is included.

As a courtesy to our patients, we are happy to bill your medical insurance for you. Please bring your insurance card(s) with you. Also, remember to bring your glasses and a list of any medications you take, when you come in for your examination. New patients may need to have their pupils dilated for a complete eye exam. We recommend you **bring a driver with you for your first visit**, as the dilating drops can make your eyes sensitive to sunlight for a few hours after the visit.

We are located at 1280 S. Victoria Avenue, Suite 160. This is the first driveway on the right after crossing the Ralston Avenue intersection going north on Victoria. Coming south on Victoria, simply make a U turn at Ralston, and turn right at the first driveway. We are in a gray two-story medical building across from Marie Callender's Restaurant. Parking is located at the front of the building, or underneath the building with elevator service to the first floor.

If you need to cancel or reschedule your appointment kindly give us at least 24 hours advanced notice.

Our goal is to provide you with state-of-the-art ophthalmology care in a personalized, caring environment. We thank you for choosing our practice, and we will make every effort to ensure that your visit to our office is a pleasant experience. If you have any questions, please do not hesitate to call the office.

Sincerely,

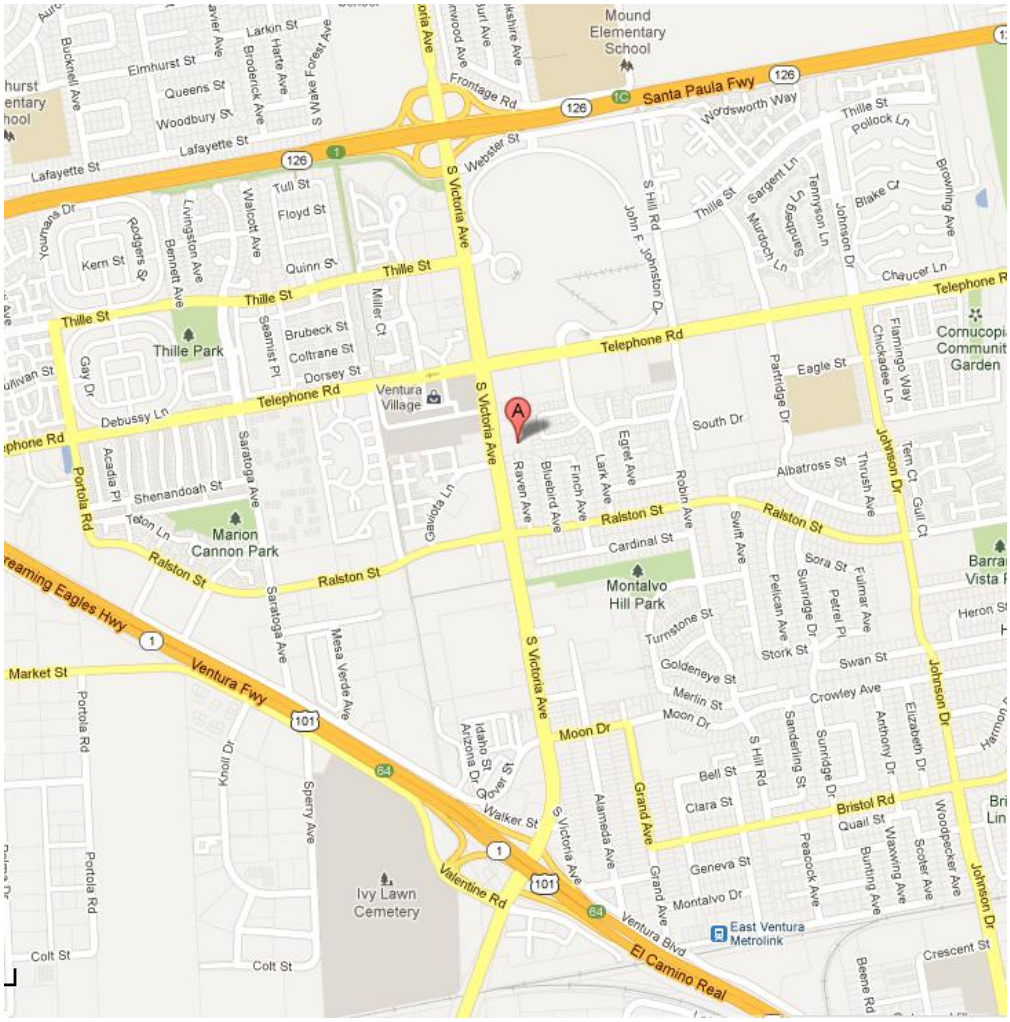
JillAnne W. McCarty, MD, PhD

Our Location

We are located on Victoria Avenue, one block south of the Government Center, across from Marie Callender's Restaurant.

Heading north on Victoria Avenue, turn right into the first driveway after crossing Ralston Avenue.

Parking is available at the front or underneath the building, with an elevator convenient to our first floor suite.



***Today's Date*_____**

Patient Information

Name:_____ Age: _____ Date of Birth: _____
LAST FIRST MIDDLE

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Cellular Phone_____ _____

SS#_____Driver's License No:_____State_____

Employer: _____ _____Occupation_____

Work Phone: _____

Employer's Address_____ City_____State_____Zip_____

Financially Responsible Party: _____ Relationship to Patient: _____

Insurance Information

Primary Insurance Co.: _____

Policy #_____ Subscriber's Name_____

Secondary Insurance Co.: _____

Policy #: _____ Subscriber's Name: _____

Emergency Information

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____Cellular Phone_____

Please also complete the other side of this form

Financial Policy

Please take a moment to read the following financial policy information:

Missed Appointments: We have reserved a special time for your eye examination, and Dr. McCarty and her staff will be ready to serve you. In the event that you are not able to keep a scheduled appointment, we ask that you notify our office at **least 24 hours in advance**. Missed appointments not only delay your necessary treatment, but prevent us from accommodating others who need care. For this reason, a fee of $50 will be billed for missed appointments without adequate notice.

_____

Patient's Signature Date

Refraction: A refraction is a diagnostic test that is performed to determine a patient's best vision. It is a necessary test used for prescribing glasses as well as helping to determine if there is a medical problem with the eye preventing 20/20 vision. It is also required by most insurance plans prior to eye surgery. Most insurance carriers do not cover this portion of the examination. **Medicare requires us to bill the fee for this service to our Medicare patients.**

If a refraction is performed during your exam, there is a $50 fee, collected at the time of the visit. We will be happy to bill your insurance if your policy covers a refraction. If you would like to be billed for this service, the fee is $65 to cover our billing and mailing costs.

Forms: DMV, employer, insurance, or other special forms will be happily filled out for you by Dr. McCarty. These forms are completed after-hours, and will be mailed to you. There is a $30 charge for completion of forms.

Consent: I consent to necessary medical care and treatment by JillAnne W. McCarty, MD, PhD. I authorize release of any medical information necessary to process all claims and request all payments to be made directly to JillAnne W. McCarty, MD, PhD. I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I authorize Dr. McCarty's office to bill my insurance and receive payment for the duration of my care. I understand that if I am determined not to be eligible for the health care or vision care provided, I agree to pay all charges in full within thirty (30) days of receiving notification. I have read all the information on this sheet. I certify that the information I have provided is true and complete to the best of my knowledge. I will notify you of any changes in the information above or any changes in my health status.

_____

Patient or financially responsible party signature Date

NEW PATIENT MEDICAL HISTORY

Please complete both sides of this form and return it to the receptionist. Thank you!

Patient name: _____ Sex: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____ Optometrist: _____

Who referred you to this office? _____

PREVIOUS EYE EXAMS AND GLASSES

What do you wear for vision correction? □ Glasses □ Reading Glasses □ Contact Lenses □ Nothing

Have you had vision correction surgery? □No □RK □PRK □LASIK □Other _____

Who performed your last eye exam? _____ When? _____

When was your glasses or contact prescription last changed? _____

MEDICAL EYE HISTORY

Please place an "X" next to any of the following eye problems you are currently having:

____ blurred vision	____ headaches	____ excessive tearing	____crossed eyes
____ distorted vision	____ itching	____ bump on eyelid	____ wandering eyes
____ difficulty reading	____ redness	____ droopy eyelids	____ squinting
____ holding things too close	____ pain	____ puffy eyelids	____ double vision
____ holding things too far	____ discharge	____ floaters	____ light sensitivity
____ eye discomfort	____ scratchy	____ flashing lights	____ other (list below)

_____

Please indicate with an "X" whether or not you have ever had any of the following eye conditions:

____ cataract	____ retinal detachment	____ lazy eye (amblyopia)
____ glaucoma	____ macular degeneration	____ crossed eyes (strabismus)
____ corneal disease	____ eyelid problem	____ other (please list) _____

Have you ever had any eye surgery? □No. If yes, please list type, which eye, and approximate date.

_____	_____	_____	_____	_____	_____
type	eye	date	type	eye	date
_____	_____	_____	_____	_____	_____
type	eye	date	type	eye	date

EYE MEDICATIONS

Please list all prescription and non-prescription eye medications you are currently using, which eye, and how often.

_____	_____	_____	_____	_____	_____
name	which eye	how often	name	which eye	how often
_____	_____	_____	_____	_____	_____
name	which eye	how often	name	which eye	how often

Please turn form over and complete the other side.

NEW PATIENT MEDICAL HISTORY CONTINUED

ALLERGIES

□ None. If yes, please list: _____

GENERAL MEDICAL HISTORY

Please list all non-eye medications you are taking (e.g. heart medications, blood pressure medications, aspirin, vitamins)

name	how often	name	how often	name	how often

Please list all surgeries you have had and the approximate year they were done.

name	date	name	date	name	date

Have you ever had a bleeding problem? □No. If yes, please describe: _____

Have you or a blood relative ever had a problem with anesthesia? □ No. If yes, please describe: _____

_____

Please indicate with an "X" whether or not you personally have ever had any of the following medical conditions:

____ diabetes	____ stroke	____ cancer	____ AIDS or HIV
____ high blood pressure	____ kidney disease	____ hepatitis	____ poor hearing
____ heart disease	____ liver disease	____ arthritis	____ headaches
____ asthma or emphysema	____ thyroid disease	____ tuberculosis	____ autoimmune disease
____ extreme weight change			

Tobacco use: □No. If yes, number of packs per day: _____
Alcohol use: □ Never □ Occasional □ Weekly □ Daily

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? □ No. If yes, indicate which relative(s).

_____ cataract	_____ cancer	_____ retinal detachment
_____ glaucoma	_____ high blood pressure	_____ strabismus (crossed eyes)
_____ diabetes	_____ macular degeneration	_____ other (please list below)

_____

Signature of person completing form _____ Date _____

Print name if different from patient _____ Relationship to patient: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date of Request_____

Patient's Name (please print)

Address

City State Zip Code

Date of Birth Social Security Number

I hereby request that my medical records be released to:

□ **TO** □ **FROM** **JILLANNE W. MCCARTY, MD, PhD**
DISEASES AND SURGERY OF THE EYE
1280 S. VICTORIA AVE., SUITE 160
VENTURA, CA 93003
TEL (805) 658-3937 FAX (805) 658-3930

□ **TO** □ **FROM**

Physician/ Optometrist's Name

Address

Telephone/Fax

I also give my permission to Dr. JillAnne McCarty, MD, PhD, to send a summary of her findings and treatment plan regarding my eye examination to my primary care physician and referring eye care specialist for continuity of care. I acknowledge that this permission can be limited or cancelled at any time at my request.

Signature of Patient Date

Signature of Person Acting on Behalf of Patient Date

JillAnne W. McCarty, M.D., Ph.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Dr. McCarty to use and disclose protected health information (PHI) about me in order to carry out treatment, payment, and healthcare operations (TPO).

Dr. McCarty's office may call my home or other locations and/or persons _____ and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

I give my consent for Dr. McCarty's office to mail, or e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that Dr. McCarty reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to JillAnne W. McCarty, MD, PhD, Privacy Officer, at 1280 South Victoria Avenue, Suite 160, Ventura, Ca. 93003.

I have the right to request that Dr. McCarty restrict how she uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound in this agreement.

By signing this form, I hereby consent to Dr. McCarty's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. McCarty may decline to provide treatment to me.

I acknowledge that I have read (or had the opportunity to read) the Privacy Notice.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Patient

_____
Print Name of Legal Guardian, if applicable

_____
Date