ATHENA EYE CARE
ADVANCED OPHTHALMIC CARE

Athena Eye Care
26800 Crown Valley Pkwy, STE 340
Mission Viejo, CA 92691
P: (949) 889-2020
F: (949) 288-5097

Demographics

Name _____ Preferred Name _____
(first name) *(middle name)* *(last name)*

Date of Birth _____ Gender _____ Social Security # _____

Driver's License Number _____ State Issued _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Preferred Appt Reminders ☐ Phone ☐ Text ☐ Email *(Text and email require consent on Page 5.)*

How did you hear about us? _____

Marital Status _____ Partner Name _____

Employer _____ Occupation _____ Primary Language _____

Ethnicity ☐ Hispanic/Latino ☐ non-Hispanic/Latino ☐ Decline to Answer

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer ☐ Other

Emergency Contact Name and Number _____

Insurance

Primary Insurance _____

Policy/ID Number _____ Group Number _____

Name of Subscriber _____ Relation ☐ Self ☐ Spouse ☐ Parent

Subscriber's Employer _____ Subscriber's Date of Birth _____

Secondary Insurance _____

Policy/ID Number _____ Group Number _____

Name of Subscriber _____ Relation ☐ Self ☐ Spouse ☐ Parent

Subscriber's Employer _____ Subscriber's Date of Birth _____

ATHENA EYE CARE
ADVANCED OPHTHALMIC CARE

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name _____ Date of Birth _____

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Athena Eye Care for services rendered to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for processing and reimbursement of claims. If another health insurance provider is listed as a Secondary Insurance, my signature likewise authorizes release of the information to the insurer shown.

Other Insurance: I request that payment of authorized benefits be made on my behalf to Athena Eye Care for services rendered to me. I authorize any holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for the processing and reimbursement of claims.

Patient is responsible for deductible balances, co-insurance, and non-covered amounts. Payment(s)/Copayment(s) are due at the time service is rendered. Athena Eye Care does not have the power to waive copayments and deductibles. You are responsible for knowing your insurance benefits.

Athena Eye Care does not participate in vision insurance plans; please ask our staff about the nominal refraction fee for glasses. Medical forms to be filled by a physician and medical records are $25.00. FMLA packets are $40.00.

No show policy: $35.00 no show fee. At least 24-hour notice is required to reschedule.

AB-1278 notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

_____ _____

Signature of Patient or Authorized Representative Date

ATHENA EYE CARE
ADVANCED OPHTHALMIC CARE

HIPAA Privacy Authorization Form

I authorize Athena Eye Care to use and disclose my protected health information (PHI). Uses and disclosure for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

This authorization for release of information covers the period of healthcare from all past, present, and future periods. This PHI may be used for medical treatment or consultation, billing or claims payment, or other purposes deemed necessary by Athena Eye Care.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

If desired, please list the name(s) of the person(s) who has permission to access to your protected health information. Please also list the type of information they have access to, such as entire medical records or specific dates of service.

Name _____ Phone _____

Relationship _____ Information _____

Name _____ Phone _____

Relationship _____ Information _____

My signature below acknowledges the receipt of Athena Eye Care's privacy policies. I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.

Printed Name _____ Date of Birth _____

Signature _____ Date _____

Relationship to patient (i.e. patient is a minor) _____

ATHENA EYE CARE
ADVANCED OPHTHALMIC CARE

Medical History

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

Reason for Visit _____

Primary Care Provider _____ **Phone** _____

Referring Provider _____ **Phone** _____

Pharmacy Address _____ **Phone** _____

Do you have, or have you had in the past, any of the conditions listed below?

	Yes	No		Yes	No
Autoimmune Conditions	☐	☐	Heart Disease	☐	☐
Arthritis	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Neuro Conditions	☐	☐
Diabetes	☐	☐	Thyroid Issues	☐	☐
GI Issues	☐	☐	Tuberculosis	☐	☐

Please specify or include any other conditions not listed above:

Please list all of the medications you are taking:

Please list all of your medication-related allergies:

Please list any surgeries you have had:

Please list any history of eye issues that you or your family have:

Smoking Status:

- Are you a current tobacco smoker? ☐ Yes ☐ No
- Are you a former smoker? ☐ Yes ☐ No

If yes, start date: _____ end date: _____

_____ _____

Signature Date

Relationship to patient (i.e. patient is a minor) _____

ATHENA EYE CARE
ADVANCED OPHTHALMIC CARE

CONSENT FOR TREATMENT, AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

CONSENT TO TREAT - I understand that by signing this Consent Form, I specifically acknowledge and provide written, informed consent for the clinical professionals at Athena Eye Care to provide medical treatment they deem necessary or appropriate to me or, if applicable, to my minor child and/or dependent after consultation with me, the parent or legal representative.

PARTICIPATING INSURANCE – I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to for any service furnished to me, my minor child, and/or my dependent by Athena Eye Care. I authorize Athena Eye Care and its staff to release to my insurance carrier and its agents, any information concerning healthcare, advice, or treatment provided to me, my minor child, and/or dependent, that is needed to determine these benefits, the benefits payable for related services, and/or to facilitate payment to Athena Eye Care.

CONSENT TO PRESCRIBE, E-PRESCRIBE, AND OBTAIN MEDICATION HISTORY

I understand that by signing this Consent Form, I specifically acknowledge and provide written, informed consent for the clinical professionals at Athena Eye Care to prescribe medications to me or, if applicable, to my minor child and/or dependent after consultation with me, the parent or legal representative.

I understand that by signing this Consent Form, I specifically acknowledge and provide written, informed consent for Athena Eye Care to transmit prescriptions electronically, as permitted, to the pharmacy that I delegate as my primary pharmacy provider.

I understand that by signing this Consent Form, I specifically acknowledge and provide written, informed consent for Athena Eye Care to obtain the history of all of my or my child's past prescriptions dating back two years from pharmacies and/or pharmacy benefit managers, and I understand that those prescriptions may become a part of my or my child's electronic health record.

COMMUNICATION PREFERENCES

Stay in the loop with Athena Eye Care

Athena Eye Care sends short check-ins, educational videos, surgical preparation guides, and occasional updates by text and email to help you make confident decisions about your care. These are educational and promotional communications. We do not sell, rent, or share your personal information with any third party. You can unsubscribe anytime by replying STOP to any text or clicking the unsubscribe link in any email.

- ☐ Yes, send me helpful text messages from Athena Eye Care
- ☐ Yes, send me helpful emails from Athena Eye Care

Appointment-related messages

We will also send appointment confirmations, reminders, and care instructions related to your visits.

- ☐ I agree to receive appointment-related texts and emails from Athena Eye Care

Checking a "Yes" box authorizes Athena Eye Care to use my name and contact information for that purpose. Message and data rates may apply. I may revoke any consent in writing or by replying STOP at any time. Consent for these communications is optional and not required for treatment.

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

_____ _____

Signature of patient or authorized representative | Date