Matthew L. Hecht, M.D.
Patient Registration
Please Print

Title: □Mr. □Mrs. □ Miss. □Ms. □ Dr. **Patient's Name: _____** **Suffix: _____**
Last First Middle

Marital Status: □Divorced □Domestic Partner **Soc. Sec. #: _____-_____-_____**

□Married □Single □Separated □Widow **Sex:** □ Male □ Female

Date of Birth: _____-___- _____ Age: _____ **E-Mail: _____**

Address: _____ **Driver's License Number: _____**

City: _____ State: _____ Zip: _____

Home Phone: (____)_____**Work Phone:** (____)_____ext.____ **Cell Phone**: (____)_____

Race: (Select all that apply) □American Indian or Alaska Native □Asian □Black or African American

□Native Hawaiian or Pacific Islander □Latin American □White □Decline to Specify

Ethnicity: (Select all that apply) □African American □American □American Indian □Chinese

□European American □Hispanic or Latino □Not Hispanic or Latino □Unknown □Decline to Specify

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How were you referred to our practice? □ Family/ Friend □ Doctor □ Insurance □ Phone Book

□ Staff □ Internet □ Other: _____

Whom may we thank for referring you? _____

Patient Employer: _____ Occupation**: _____**

Work Address**: _____** City**: _____** State: ___ Zip: _____

Work Phone: (___)_____ Ext.: _____

Please continue to the next page →

If the patient is a dependent or minor, the following pertains to the insured

Insured's Name: _____ Relationship: _____

Insured's Employer Name:_____ Phone: (___)_____
_____

Work Address:_____ City:_____ State:____ Zip:
_____

Insured's Soc. Sec. #: _____-_____-_____ Insured's Date of Birth: _____-_____-_____
_____

Personal Physician:_____ Phone: (_____)_____

Address:_____ City: _____ State: _____ Zip:_____
_____

Emergency Contact: _____ Phone: (_____)_____

Emergency Contact:_____ Phone: (_____)_____
(Not living with you)

Are you currently a contact lens wearer or have worn contact lenses in the past? ____ Yes ___No

Are you interested in being fitted with contact lenses or an annual contact lens exam? ___Yes ____No

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AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby consent and authorize the performance of all treatments, surgery and medical services by the physicians and staff which they may deem advisable and to furnish information relating to all claims for benefits submitted on my behalf and/ or my dependents. I hereby assign all payments for medical services rendered or devices to be rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____

MEDICAL HISTORY QUESTIONNAIRE

Name: Date:

Date of Birth: _____ Date of last eye exam: _____

List any **medications** you currently take (Rx and over-the-counter):_____

_____

Do you have **allergies** to any medications? **YES NO**
If **YES**, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growth, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusión, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases? (circle all that apply) YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? …… YES NO
Have you ever had a blood transfusion? …….. …….YES NO
Do you drink alcohol? …… YES NO
Do you smoke? ……... YES NO

Physician's Signature _____ ***Date*** _____

HECHT EYE INSTITUTE

□ **South Bay:**
4223 Redondo Beach Blvd.
Lawndale, CA 90260
(310) 370-5648
Fax: (310) 370-0449
www.southbaylaser.com

MATTHEW L. HECHT, M.D.
Board Certified Ophthalmologist ♦ Assistant Clinical Professor, UCLA

□ **Beverly Hills:**
9001 Wilshire Blvd. Ste. 306
Beverly Hills, CA 90211
(310) 273-3014
Fax: (310) 273-6956

□ **Marina Del Rey:**
3019 Washington Blvd.
Marina del Rey, CA 90292
(310) 577-6600
Fax: (310) 577-6601
www.marinaeyecenter.com

Patient's Name: _____

Date of Birth: _____

ASSIGNMENT OF BENEFITS
Medicare and/or other insurance

I hereby authorize payment of my medical, surgical, and vision benefits to Hecht Eye Institute. I authorize this office to release any information required to process all claims for reimbursement on my behalf. The above providers participate with Medicare and other insurances; therefore I understand that I AM responsible for applicable deductibles, co-insurances, co-payments, and non-covered services. I understand I am financially responsible for any charges incurred if my insurance does not pay. A copy of this authorization may be used in place of the original.

_____ _____

Patient Signature Date
(Guardian signature for minors)

REFRACTION AND CONTACT LENS POLICY

A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lens. Most medical insurance plans, including Medicare, DO NOT cover refractions, routine eye examinations (where no medical eye problem is known or suspected), or contacts lens evaluations. If you are interested in a new prescription for glasses of contact lenses, please inform the office staff so that the proper examination can be performed.

_____ _____

Patient Signature Date
(Guardian signature for minors)

Matthew L. Hecht, M.D.
Board Certified Ophthalmologist

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

In compliance with the HIPAA Patient Privacy Policy, this authorization allows Hecht Eye Institute to release any of your protected medical information to individuals that you wish to specify.

I hereby authorize Hecht Eye Institute to release information regarding my medical history and treatment by means of verbal communication via phone or in person, by mail or fax, to the person(s) listed below:

_____

Name and Relationship to Patient

_____

Name and Relationship to Patient

If it becomes necessary to contact you by phone, please list the number(s) where you wish for us to call.

_____

Phone number and type of phone line (home, cellular business, etc.)

May we leave messages, such as lab results, appointment reminders, or other medical information on an answering device, or with another person who answer the phone at that location?

☐ Yes ☐ No

_____ _____

Signature of patient or legal representative Relationship

_____ _____

Patient's name and date of birth (PRINT) Date

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Office:

The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identifies by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

_____ _____

Signature of patient or legal representative Relationship to Patient (if applicable)

Date: _____

MATTHEW L. HECHT, M.D.

OPHTHALMOLOGY

4161 REDONDO BEACH BOULEVARD, 3RD FLOOR

LAWNDALE, CALIFORNIA 90260

(310) 370-5648

AUTHORIZATION FOR RELEASE OF RECORDS

I _____ hereby authorize _____

(NAME OF PHYSICIAN)

to furnish all information to _____ concerning this illness.

(NAME OF COMPANY/MEDICAL DOCTOR)

Date _____ Signed _____

***SIGNING THIS DOCUMENT AUTHORIZES THE RELEASE OF RECORDS TO DESGINATED COMPANY OR MEDICAL DOCTOR. NO RECORDS WILL BE RELEASED WITHOUT YOUR SIGNED APPROVAL ***