1513 S. Grand Avenue Suite 200
Los Angeles, CA 90015
Tel: 213-234-1000
Fax 213-234-1001

Steven C. Dresner, MD
Michael A. Burnstine, MD
Melanie H. Erb, MD
David B. Samimi, MD
Priya D. Sahu, MD

Specialist in: Ophthalmic Plastic and Reconstructive Surgery
Cosmetic Surgery & Orbital and Lacrimal Surgery

PRE-VISIT INFORMATION

PLEASE BRING THE FOLLOWING ITEMS WITH YOU:

- Current Identification
- All Insurance Cards
- HMO patients, please bring a copy of your insurance authorization.
- Any prescription medication(s) you are taking: A blank form is attached.
- A translator, if you are non-English speaking.
- Method of Payment
  (Cash, Check, Visa, MasterCard, Discover Card, American Express are accepted)

PLEASE DO NOT MAIL IN YOUR PAPERWORK. BRING YOUR COMPLETED FORMS TO YOUR APPOINTMENT. FAILURE TO DO SO MAY CAUSE YOUR WAIT TIME TO BE LONGER.

There is ample parking. Unfortunately, we are unable to validate parking. For our Valencia and Torrance locations, parking is complimentary.

DOWNTOWN L.A.	1513 S. Grand Avenue Suite 200 * Los Angeles, CA 90015 * Tel: 213-234-1000 * Fax: 213-234-1001
ENCINO	5363 Balboa Blvd Suite 246*Encino, CA 91316* Tel: 213-234-1000 * Fax: 213-234-1001
PALM DESERT	73271 Fred Waring Drive *Palm Desert, CA 92200* Tel: 213-234-1000 * Fax: 213-234-1001
PASADENA	625 S. Fair Oaks Ave Suite 265 * Pasadena, CA 91105 * Tel: 626-564-0004 * Fax: 626-564-4261
SANTA MONICA	2121 Wilshire Blvd Suite 301 * Santa Monica, CA 90403 * Tel: 310-453-1763 * Fax: 310-453-9176
TORRANCE	3400 Lomita Blvd Suite 401*Torrance, CA 90505 * Tel: 310-530-9482 * Fax: 310-453-9772
VALENCIA	27879 Smyth Drive * Valencia, CA 91355 * Tel: 213-234-1000 * Fax: 213-234-1001

Eyesthetica

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

Upon arrival for your appointment, you will be provided with a physician–patient arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party select an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us!

*** Physician-Patient Arbitration Agreement will be provided upon arrival***

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PATIENT INFORMATION FORM

NAME: _____ MALE: _____ FEMALE: _____

MARRIED: _____ SINGLE: _____ DIVORCED: _____ WIDOWED: _____ SIGNIFICANT OTHER _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____- _____-_____

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: ( ) _____ -_____ BUSINESS PHONE: ( ) _____ - _____

CELL PHONE: ( ) _____ - _____ EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

IF PATIENT IS A MINOR, NAME OF RESPONSIBLE PARENT: _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY OR IF WE NEED TO CHANGE AN APPOINTMENT AND CANNOT REACH YOU?

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: ( ) _____ - _____ BUSINESS PHONE: ( ) _____ - _____

INSURANCE INFORMATION:

PRIMARY CARRIER:

INSURANCE NAME: _____

POLICY NUMBER: _____

GROUP NUMBER: _____

SECONDARY CARRIER:

INSURANCE NAME: _____

POLICY NUMBER: _____

GROUP NUMBER: _____

_____ _____

Signature of Patient/Guardian **Today's Date**

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REFERRING PHYSICIAN FORM

It is important for the following information to be filled out completely. Please provide us as much information as possible.

PRIMARY CARE PHYSICIAN/ INTERNIST:

DOCTOR'S NAME: _____

PHONE #: _____ **FAX #:** _____

ADDRESS: _____

_____

_____

REFERRING PHYSICIAN:

DOCTOR'S NAME: _____

PHONE #: _____ **FAX #:** _____

ADDRESS: _____

_____

_____

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REVIEW OF SYSTEMS

Please answer the following questions about your medical status and history:

1. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

   □ **No** □ **Yes** If yes, what kind?_____

   _____

2. Have you ever had eye surgery?

   □ **No** □ **Yes** If yes, what kind? _____which eye? _____date of surgery? _____

3. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?

   □ **No** □ **Yes** If yes, what kind? _____

   _____

4. Have you ever had any other surgery?

   □ **No** □ **Yes** If yes, what kind? _____date of surgery? _____

Do you currently have any of the following problems: **If yes, what kind?:**

Chronic fever, unexpected weight loss/gain, fatigue	**No**	**Yes**	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	**No**	**Yes**	_____
Heart problems (e.g., chest pain, irregular heart beat)	**No**	**Yes**	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	**No**	**Yes**	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	**No**	**Yes**	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	**No**	**Yes**	_____
Skin problems (e.g., rashes, excessive dryness)	**No**	**Yes**	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	**No**	**Yes**	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	**No**	**Yes**	_____
Psychiatric problems (e.g., depression, anxiety)	**No**	**Yes**	_____

Do any eye diseases or medical problems run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration, cataracts)? **No Yes** If yes, what kind and which family member? _____

_____

History of Tuberculosis	**No**	**Yes**	_____
Any symptoms of tuberculosis	**No**	**Yes**	_____

5. Do you smoke? □**No** □**Yes** If yes, how often? _____ For how many years? _____
   - □ current every day smoker
   - □ current some day smoker
   - □ former smoker
   - □ never smoker
6. Drink alcohol? □**No** □**Yes** If yes, how much? _____
7. Drink coffee or tea? □**No** □**Yes** If yes, how much? _____
8. Illegal drug use? □**No** □**Yes** If yes, what kind? _____

Current Height _____ **Current Weight** _____

_____ _____

Patient Signature **Date**

_____ _____

MD Signature **Date**

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Patient Screening for Aerosol Transmissible Diseases (ATD)

In compliance with California OSHA Title 8, Section 5199, health care facilities must pre-screen patients for aerosol transmissible diseases. Procedures are not performed on patients suspected or identified as having aerosol transmissible diseases.

Do you have:

A history of Tuberculosis? Yes No If yes, explain:_____

Symptoms of tuberculosis?

Productive cough (> 3 weeks):	**Yes**	**No**	**If yes, explain:**_____
Bloody sputum	**Yes**	**No**	**If yes, explain:**_____
Night sweats	**Yes**	**No**	
Fatigue	**Yes**	**No**	
Malaise	**Yes**	**No**	
Fever	**Yes**	**No**	
Unexplained weight loss	**Yes**	**No**	

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

Do you have:			**How long? Explain:**
Fever?	**Yes**	**No**	_____
Body aches?	**Yes**	**No**	_____
Runny nose?	**Yes**	**No**	_____
Sore throat?	**Yes**	**No**	_____
Headache?	**Yes**	**No**	_____
Nausea?	**Yes**	**No**	_____
Vomiting or diarrhea?	**Yes**	**No**	_____
Fever and respiratory symptoms?	**Yes**	**No**	_____
Severe coughing spasms?	**Yes**	**No**	_____
Painful, swollen glands?	**Yes**	**No**	_____
Skin rash, blisters?	**Yes**	**No**	_____
Stiff neck, mental changes?	**Yes**	**No**	_____

Chronic Respiratory Diseases (NOT ATD's, and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199:

Do you have:

Asthma?	**Yes**	**No**	Chronic upper airway cough syndrome "postnasal drip?	**Yes**	**No**
Allergies?	**Yes**	**No**	Gastroesophageal reflux disease (GERD)?	**Yes**	**No**
Emphysema?	**Yes**	**No**	Chronic obstructive pulmonary disease (COPD)?	**Yes**	**No**
Bronchitis?	**Yes**	**No**	Dry cough from ACE inhibitors?	**Yes**	**No**

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MEDICATION LIST

Allergies:

Latex Allergy? _____

Allergic To:	Describe Reaction:

List all medications you are taking:

Prescription, over the counter medications, eye drops or ointments and herbal supplements.

Name	Dosage	How often do you take it?	Reason for taking

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At ***EYESTHETICA***, we have always kept patient health information secure and confidential. A new law requires us to continue maintaining patients' privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations.

We may use your information to contact you. For example, we may send a newsletter or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor/owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization/consent. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclose we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (213) 234-1000.

As required by the new law, this notice goes into effect as of April 14, 2003.

Acknowledgment: I have received a copy of the ***EYESTHETICA'S***, Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____
If signing as a parent or guardian, please note the name of the patient: _____

Eyesthetica

In an effort to comply with requirements mandated by the federal government, please provide us with the following information:

RACE:

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Hispanic
____ Indian
____ Multiracial
____ Pacific Islander
____ Other Race
____ Unknown / Decline to Answer
____ White

PREFERRED LANGUAGE:

____ Arabic
____ Chinese
____ English
____ Farsi
____ French
____ Korean
____ Russian
____ Spanish
____ Tagalog
____ Thai
____ Vietnamese
____ Other _____

ETHNICITY:

____ Hispanic or Latino
____ Not Hispanic or Latino
____ Unknown / Decline to Answer

_____ _____

Signature of Patient/Guardian **Today's Date**

Eyesthetica

SIGNATURE ON FILE

INITIAL:

_____Any monies payable to Steven C. Dresner, M.D., Michael A. Burnstine, M.D., Melanie H. Erb, M. D., David B. Samimi, M.D. and Dr. Priya D. Sahu, M.D., will be paid directly to them. I authorize any medical benefits payable to me to be paid directly to Steven C. Dresner, M.D., Michael A. Burnstine, M.D., Melanie Ho Erb, M.D., David B. Samimi, M.D and Dr. Priya D. Sahu, M.D.

_____I authorize the release of any medical information to my insurance carrier as requested by them. I permit a copy of this authorization to be used in place of the original.

_____I hereby give permission to Drs. Steven C. Dresner, Michael A. Burnstine, Melanie H. Erb, David B. Samimi, and Priya D. Sahu, to photograph, video or otherwise illustrate my clinical condition as deemed advisable for diagnostic, educational, or research purposes. I further authorize the use of such material for teaching purposes or to illustrate scientific papers, books, or lectures at any time hereafter without inspection or approval, on my part, of the finished product of specific use to which this material may be applied. It is understood that in no way will I be identified by name.

_____Laboratory and other tests done outside this office: You are responsible for ensuring that these are done at a provider that is contracted with your insurance. Consult the Member Services Department of your insurance for assistance.

_____By initialing here, I grant permission to Eyesthetica and its employees, agents, partners and advertisers, to use my image and likeness, including but not limited to before and after photographs, clinical records, video and testimonial statements for unrestricted use in print and electronic mediums. The patient or the patient's guardian may request removal of photographs or electronic matter at any time in writing. I release Eyesthetica from all claims and liabilities arising out of Eyesthetica's use of my image and likeness.

_____ _____

Signature of Patient/Guardian **Today's Date**

FOR MEDICARE PATIENTS ONLY:

_____I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

_____ _____

Signature of Patient/Guardian **Today's Date**

Eyesthetica

Explanation of Practice Policy: Financial Policies
Patient's Rights and Responsibilities

PATIENTS HAVE THE RIGHT TO:

- Be treated with professionalism and respect.
- Confidentiality regarding your medical record and all other personal information.*****
- Receive explanations about tests or office procedures, or answers to any questions you may have.
- Review your medical record with your health care provider and participate in decisions regarding your healthcare.
- Consent to or refuse any medical care or treatment.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made. This includes applicable coinsurance, copayments and deductible for participating insurance companies. **EYESTHETICA** accepts cash, personal checks (in-state only), American Express Discover Card, MasterCard or Visa. There is a **$25.00** service charge for returned checks.

PPO INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your coinsurance, copayments and deductible at the time of service. You are responsible for payment of all charges. If you need assistance or have questions, please contact our **Billing Department at 213-234-1000 option # 5; between 7:00 a.m. and 4:30 p.m., Monday through Friday.**

MANAGED CARE INSURANCE:

If you are enrolled in a managed care insurance plan (i.e., HMO), we must be contracted with your Medical Group or have a Letter of Agreement in place prior to your visit along with an authorization. You will be billed for services received without prior authorization.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us. Other patients could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancellation of appointments. Excessive abuse of scheduled appointments may result in discharge from our practice.

STATEMENT OF FINANCIAL RESPONSIBILITY:

I, the undersigned, have read the above and realize that all medical charges incurred by me or my dependants for services rendered by Eyesthetica physicians, are my financial responsibility. I hereby authorize assignment and payment directly to the rendering physician. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____ _____

Signature of Patient/Guardian **Today's Date**

*Upon request, we can provide to you our notice of privacy practices. A copy is in the waiting area.