MICHAEL J. GROTH, M.D.
Ophthalmic Plastic and Reconstructive Surgery

PATIENT REGISTRATION SHEET

PATIENT'S NAME: ____ DATE:_________________

ADDRESS: ____

CITY: __________________________________ STATE: ________________ ZIP: ___________________

HOME PHONE: (   )_____________________ WORK PHONE: (   )________________________

CELL PHONE: (   )______________________ EMAIL: _____________________________________

DATE OF BIRTH: ________ SEX:____ AGE: _______ MARITAL STATUS: ____________________

DRIVERS LICENSE: ___________________

REFERRED BY: ______________________________ (If physician, list address/phone#) ____________

YOUR OCCUPATION: ___________________ EMPLOYER'S NAME: __________________________

WORK ADDRESS: ____

EMERGENCY CONTACT: _______________________________ RELATIONSHIP: ________________

CONTACT'S PHONE/ADDRESS: ____

REASON FOR TODAY'S CONSULTATION: ____

INSURANCE INFORMATION

Primary Carrier: ____ Group#:___________________
Policy Number: ____________________________________ Name of Insured: ________________________
Insured's Date of Birth: ________________ Insured's Employer: __________________________________
Employer's Phone/Address____
____
Send Claims to (Address/Phone):____

Secondary Carrier: ____ Group #: _________________
Policy Number: _____________________________________ Name of Insured: ______________________
Insured's Date of Birth: ________________ Insured's Employer: __________________________________
Employer's Phone/Address____
____
Send Claims to (Address/Phone):____
____

****YOUR CARRIER REQUIRES THE LISTING OF INSURED'S EMPLOYMENT INFO AND DATE OF BIRTH****

PLEASE CHECK HOW YOU WILL PAY FOR TODAY'S SERVICES (Due at time services are rendered): ☐ Check ☐ Cash ☐Visa/Mastercard/AMEX

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PATIENT NAME: ____ DATE: _________________
AGE: _____________ SEX: ________________ HEIGHT: ___________ WEIGHT: _____________
ALLERGIES (to medications, foods, etc.): ☐ NO KNOWN ALLERGIES

____

***ALLERGIC TO: EGGS ☐YES ☐ NO SOYBEAN ☐YES ☐ NO LATEX ☐YES ☐ NO**
*** IF YES, PLEASE EXPLAIN REACTION**:____
MEDICATIONS (taken regularly or occasionally, prescription and non-prescription):

____

HAVE YOU TAKEN CORTISONE OR STEROID MEDICATION THE PAST 6 MONTHS? ☐**YES** ☐ **NO** (If yes, please explain):____
NAME OF YOUR PRIVATE PHYSICIAN: ____
PHYSICIAN ADDRESS: _________________________________ TELEPHONE: _________________
WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAMINATION: ________________________
DO YOU HAVE ANY CURRENT OR RECENT MEDICAL PROBLEMS? PLEASE EXPLAIN:

____

ARE YOU UNDER A DOCTOR'S CARE FOR THIS/THESE? ________________________________
DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (Please check):

- ☐ **High Blood Pressure**
- ☐ **Diabetes**
- ☐ **Heart/Circulation problems**
- ☐ **Mitral Valve Prolapse**
- ☐ **Pacemaker**
- ☐ **Lung/Respiratory problems**
- ☐ **Asthma**
- ☐ **Dizziness/Fainting**
- ☐ **Blood or Bleeding Skin Problems**
- ☐ **Glaucoma**
- ☐ **Implants**
- ☐ **Anemia**
- ☐ **Kidney/Urinary Problems**
- ☐ **Cancer**
- ☐ **Seizure or Epilepsy**
- ☐ **Stroke**
- ☐ **Hiatal Hernia**
- ☐ **AIDS/HIV Positive**
- ☐ **Hepatitis B or Hepatitis C**
- ☐ **Other (please list):_________________**
- ☐ **NONE OF THE ABOVE**

DO YOU WEAR CONTACT LENSES? ☐**YES** ☐ **NO**

HAVE YOU EVER HAD AN ABNORMAL: EKG ☐**YES** ☐ **NO** CHEST X-RAY ☐**YES** ☐ **NO**
BLOOD OR LAB TEST ☐**YES** ☐ **NO**
LIST DATES AND TYPES OF PREVIOUS SURGERIES: ____________________________________

____

HAVE YOU OR A BLOOD RELATION EVER HAD ANY COMPLICATIONS OR PROBLEMS WITH SURGERY OR ANESTHESIA? IF YES, PLEASE EXPLAIN: ___________________________

____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANYTHING OTHER THAN SURGERY? IF YES, PLEASE EXPLAIN: ____

DO YOU SMOKE? ☐**YES** ☐ **NO** IF YES, HOW MUCH? ________________________________

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐**YES** ☐ **NO** IF YES, HOW MUCH? __________

ARE YOU PREGNANT? ☐**YES** ☐ **NO** NURSING? ☐**YES** ☐ **NO**

PATIENT SIGNATURE: ____ **DATE:** ____________

REVIEWED BY: ____ **DATE:** ____________

PHYSICIAN SIGNATURE: ______________________________________ **DATE:** ____________

MICHAEL J. GROTH, M.D.
Ophthalmic Plastic and Reconstructive Surgery

FINANCIAL AGREEMENT AND AUTHORIZATION OF BENEFITS

PATIENT'S NAME____

RESPONSIBLE PARTY__________________________**RELATION:**_________________

1. We are NOT preferred providers for any insurance companies. We always require payment at the time services are rendered. We will be happy to help you bill your insurance carrier in order for you to be reimbursed for medically necessary services. I do hereby agree that I am ultimately responsible to pay for all services rendered to me by Michael J. Groth, M.D. I have read the above office policy and understand it.

____ _______________________
SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

2. I authorize payment of medical benefits for which I am eligible to Michael J. Groth, M.D. for all services/supplies rendered to me. A copy of this authorization is as valid as the original, and this authorization will remain in effect until rescinded by me in writing.

____ _______________________
SIGNATURE OF INSURED/AUTHORIZED PERSON DATE

3. I authorize the release of any medical or other information necessary to process claims to my insurance company. A copy of this authorization is as valid as the original, and this authorization will remain in effect until rescinded by me in writing.

____ _______________________
SIGNATURE OF INSURED/AUTHORIZED PERSON DATE

MICHAEL J. GROTH, M.D.
Ophthalmic Plastic and Reconstructive Surgery

YOU ONLY HAVE TO COMPLETE THIS FORM IF YOU HAVE MEDICARE

PRIVATE CONTRACT FOR MEDICARE BENEFICIARY

Dr. Michael Groth has opted out of Medicare. The Medicare Administration requires that all Medicare patients read, understand and sign the following:

I am aware that the office requires payment at the time services are provided. I do hereby agree that I am ultimately responsible to pay for all services rendered to me by Michael J. Groth, M.D.

____
Initials

I agree that I cannot submit a claim or request Michael J. Groth, M.D. to submit a claim for payment under Medicare, even if such items and services are otherwise covered by Medicare.

____
Initials

I acknowledge that Medigap plans do not, and other supplemental insurance plans may choose not to, make payment for items and services rendered by Michael J. Groth, M.D.

____
Initials

I acknowledge that Michael J. Groth, M.D. is not limited in the amount that he may charge for the items and services rendered. I understand that no reimbursement will be provided by Medicare to Michael J. Groth, M.D. for services rendered.

____
Initials

I understand that a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to me under this contract.

____
Initials

I, ________________________________, hereby understand that Michael J. Groth, M.D. is not a provider for Medicare and that I am ultimately responsible for items and services rendered. I have read the above office policy and understand it.

________________________________ ____________
Signature Date

MICHAEL J. GROTH, M.D.

Ophthalmic Plastic and Reconstructive Surgery

MALIGNANT HYPERTHERMIA AND VENOUS THROMBOEMBOLISM ASSESSMENT

HAVE YOU EVER EXPERIENCED THE FOLLOWING:

YES	NO		YES	NO	
		Unexplained Muscle Cramping or Spasms			Headaches
		Excessive Sweating			Heatstroke
		Night Sweats			Heat Intolerance
		Fatigue			Elevated Blood Pressure
		Nausea or Motion Sickness			Hypothyroidism
		Dizziness			Fevers following Exercise or Anesthesia
		Excessive Thirst			Dark Chocolate Colored Urine

Please indicate how many caffeinated beverages you consume daily:______________________________

Have any blood relatives had problems with anesthesia? No ☐ Yes ☐, Please Explain Below

____

Do you have a muscle or neuromuscular disorder? No ☐ Yes ☐, Please Explain Below

____

VTE RISK ASSESSMENT

Add 5 points for each of the following statements that apply:

☐ Recent elective hip or knee joint replacement surgery.

☐ Broken hip, pelvis or leg within the last month.

☐ Serious trauma within the last month (i.e. a fall, broken bone or a car accident.

☐ Spinal cord injury with paralysis within the last month.

Add 3 points for each of the following statements that apply:

☐ Age 75 or over.

☐ History of blood clots.

☐ Family history of blood clots.

☐ Family history of blood-clotting disorders.

Add 2 points for each of the following statements that apply:

☐ Age 60-74 years.

☐ Cancer (current or previous).

☐ Recently had major surgery that lasted longer than 45 minutes.

☐ Recent laparoscopic surgery longer than 45 minutes.

☐ Plaster cast that has kept you from moving your limb within the last month.

☐ Tube in blood vessel in neck or chest that delivers blood or medicine directly to the heart (also called central venous access).

Add 1 point for each of the following statements that apply:

☐ Use of birth control or Hormone Replacement Therapy.

☐ Have been pregnant or had a baby within the last month.

☐ Age 41-60 years.

☐ Planning minor surgery in the near future.

☐ Had *major* surgery within the past month.

☐ Serious infection (i.e. pneumonia).

☐ Lung Disease (i.e. emphysema or COPD).

☐ Varicose Veins.

☐ History of Inflammatory Bowel Disease (i.e Crohn's or UC).

☐ Legs are currently swollen.

☐ Overweight or obese.

☐ Heart Attack.

☐ History of Congestive Heart Failure.

☐ Currently on bed rest or severely restricted mobility.

TOTAL SCORE: ☐ Low Risk 0-1 point, Moderate Risk 2 points, High Risk 3+ points

______________________	__________	______________________	________
Patient Signature	Date	Anesthesiologist Signature	Date
______________________	__________	______________________	________
Surgeon Signature	Date	RN Signature	Date

<u>MICHAEL J. GROTH, M.D.</u>
Ophthalmic Plastic and Reconstructive Surgery

NOTICE OF PRIVACY PRACTICES

Michael J. Groth, M.D. 9675 Brighton Way, Suite 410 Beverly Hills, CA 90210 (310) 274-2525

Effective 2017

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

<u>Treatment.</u> We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

<u>Payment.</u> We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

<u>Health Care Operations.</u> We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues are required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights
Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

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MICHAEL J. GROTH, M.D.
9675 Brighton Way, Suite 410 Beverly Hills, CA 90210 (310) 274-2525

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations, such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above 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 restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:____

Relationship to Patient:____

Signature:____

Date:____

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

______________ ___________ ______________________________________

Date Initials Reason

MICHAEL J. GROTH, M.D.
Ophthalmic Plastic and Reconstructive Surgery

MICHAEL J. GROTH, M.D.
9675 Brighton Way, Suite 410 Beverly Hills, CA 90210 (310) 274-2525

PATIENT AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:____ Relationship:_____________________________

Name:____ Relationship:_____________________________

Name:____ Relationship:_____________________________

Name:____ Relationship:_____________________________

This authorization shall remain in effect from the date signed below until revoked.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your practice at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case, you may refuse to provide that research-related treatment).

Patient Name:____

Signature:____ Date:______________

Relationship to patient, if minor:_______________________________

Privacy Officer:____