



**GLAUCOMA
CENTER OF
SAN FRANCISCO**

55 Stevenson Street
San Francisco, CA 94105
Tel: (415) 981-2020
Fax: (415) 981-2019
frontdesk@glaucomasf.com
www.glaucomasf.com

Andrew G. Iwach, M.D.
Shan C. Lin, M.D.
Terri Pickering, M.D.
Sunita Radhakrishnan, M.D.
Sophia Hsiao, O.D.

Emeritus
H. Dunbar Hoskins, Jr., M.D.
Robert N. Shaffer, M.D.,
1912-2007
John Hetherington, Jr., M.D.,
1930-2020

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ Age: _____

Gender: _____ Race: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred: Home Cell Work

E-Mail Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Referred By: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Mail Order Pharmacy

Address: _____

City, State: _____ Phone Number: _____

INSURANCE INFORMATION (please give insurance cards to receptionist to copy)

I certify that I (or my dependent) have insurance coverage as stated provided to the office. I authorize the release of any medical information necessary to process all claims and agree to have insurance payments made directly to Glaucoma Center of San Francisco to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

Signature of Patient or Patient Representative

Date



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INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient name (please print)

X _____
Patient (or person authorized to sign for patient)

Date

X _____
Witness

Date



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PATIENT E-MAIL PERMISSION

Glaucoma Center of San Francisco offers its patients the ability to communicate with healthcare providers via electronic mail (e-mail) over the Internet.

If you would like to take advantage of this service, please observe the following:

E-mail Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
 - Do not use e-mail to send or request very sensitive information without encryption. Glaucoma Center of San Francisco cannot and does not guarantee the confidentiality of any messages being sent over the Internet.
 - Messages can be misdirected or intercepted by unintended parties.
 - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
 - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
 - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date

If you do not provide this information, your healthcare provider may not be able to respond. In order to protect your confidentiality, do not place name, date of birth or medical record number in subject line.

If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the healthcare provider provided, please call the healthcare provider's office to verify you have the correct address and that the e-mail system is functioning properly.

If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call his or her office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.

I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.

I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

Patient's Name (Printed)

Date

Patient or Legal Representative Signature

Relationship to Patient



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INSURANCE AND SELF-PAY DISCLAIMER

Patients without Health Insurance Coverage

As a patient without health insurance coverage I, _____, understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail.

 Patient Signature Date

Patients with Non-Participating Health Insurance Coverage

I, _____, have been informed that the Glaucoma Center of San Francisco and its physicians are not on the participating panel for my insurance carrier and understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail.

 Patient Signature Date

Patients without Proof of Health Insurance Coverage

As a patient without a health insurance card to prove my health insurance coverage I, _____, understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail. Once I have presented proof of coverage in the form of an insurance card and the charges have been paid by my insurance company, I will be reimbursed by the Glaucoma Center of San Francisco.

 Patient Signature Date

Patients with Health Insurance Coverage Needing Verification

I, _____, understand that the health insurance plan that I have presented to the Glaucoma Center of San Francisco will be billed on my behalf, but may not be accepted, and consequently not cover the charges incurred for my visit. Should that be the case, I understand that I will be considered a Self-Pay patient and, as such, will be billed in full for the charges incurred from my visit. I further understand that I am responsible for all charges due to copays and deductibles.

 Patient Signature Date