Los Gatos Eye Care

PATIENT HISTORY AND INFORMATION

DATE _____

Name _____ Date of Birth ___/___/___
LAST FIRST MI NICKNAME

Address _____ Sex □ Male □ Female Age _____
STREET NAME

_____ Social Security Number _____
CITY STATE ZIPCODE

Home Telephone _____ Work/Cell Telephone _____

Date of Last Eye Exam ___/___/___ Email _____

Occupation _____ Employer _____

Primary Care Physician _____ Phone Number _____

Medical Insurance Carrier _____ PPO / PIO / HMO / Other

Do you have kids? Y/N If so, how many and what are their names? _____

How did you hear about us? Live in neighborhood / VSP website / lgeyecare website / friend or co-worker _____

GLASSES HISTORY

Do you wear glasses? □ Yes □ No
a) For: □ Near □ Distance □ Both
b) □ Single Vision □ Bifocals
□ Progressive □ Trifocals
c) Any Problems? _____
d) Do you wear sunglasses? □ Yes □ No
e) Are your sunglasses prescription? □ Yes □ No

CONTACT LENS HISTORY

Do you wear contacts? □ Yes □ No
Reason for stopping _____
a) □ Full Time □ Part Time □ Rarely
b) Type of Contacts?
□ Daily Wear □ Extended Wear
□ Soft Toric □ Gas Permeable
c) What cleaning solution do you use? _____
d) If you do not wear contacts, are you interested in trying them?
□ Yes □ No

SOCIAL HISTORY

Do you engage in regular exercise? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Do you smoke? □ Yes □ No

Which of the following do you do regularly?

□ Night Driving
□ Commute 20+ minutes by car
□ Work under fluorescent light
□ Work on a computer
□ Watch television 3+ hours per day
□ Work at a desk
□ Work Outdoors
□ Work with small objects
□ Read for long periods
□ Travel on airplanes
□ Frequently alternate between indoors and outdoors
□ Other _____

□ List any sports or hobbies you participate in _____

OCULAR SURFACE DISEASE HISTORY

Do your eyes ever feel or do you experience:	Never	Slight	Moderate	Severe
Gritty or sandy sensation?				
Pain or soreness?				
Fluctuating vision?				
Occasional tearing?				
Blurred vision while reading or computer use?				
Discomfort in windy conditions?				
Discomfort in Heating/Air Conditioned areas?				

FAMILY MEDICAL HISTORY

EYE DISEASES

	Yes	No	Who		Yes	No	Who
Amblyopia (Lazy Eye)				Color Blindness			
Eye Tumor				Glaucoma			
Blindness				Macular Degeneration			
Cataract(s)				Retinal Detachment			

SYSTEMIC DISEASES

	Yes	No	Who		Yes	No	Who
Arthritis				High Cholesterol			
Cancer				Stroke			
Diabetes				Kidney Disease			
Heart Disease				Lupus			
High Blood Pressure				Thyroid Disease			

PATIENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies (seasonal)			Glaucoma			Sandy or Gritty Feeling		
Excessive Weight Changes			Cataract(s)			Strabismus (Crossed Eyes)		
Ear, Nose, Throat			Macular Degeneration			Blurred Vision at Distance		
High Blood Pressure			Retinal Detachment			Blurred Vision at Near		
Asthma/Breathing Problems			Color Blindness			Distorted Vision (halos)		
Stomach Problems			Glare/Light Sensitivity			Double Vision		
Arthritis/Osteoporosis			Tired Eyes			Floaters or Spots		
Skin Problems			Amblyopia			Fluctuating Vision		
MS/Seizures			Burning Eyes			Loss of Vision		
Anxiety/Depression			Dryness			Loss of Side Vision		
Kidney Problems			Excess Tearing/Watering					
Diabetes			Eye Pain/Soreness					
Thyroid Problems			Itching					
Anemia/Blood Disorders			Mucous Discharge					
HIV/Herpes/Lime Disease			Ptosis (drooping eyelid)					
Cancer (What type?):			Redness					

Eye injuries, infections or surgeries (including LASIK) _____

Any other surgeries _____

Medications that cause reactions or sensitivities _____

Specific Allergies _____

Current Medications (including vitamins & herbal supplements) _____

_____

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and please feel free to let us know if you have any other needs or concerns we have not addressed.

_____ _____

Doctor's Signature Date

Los Gatos Eye Care

THIS NOTICE APPLIES TO THE FOLLOWING PATIENT AND/OR FAMILY MEMBERS

PRIVACY POLICY (HIPAA)

As required by Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your prior authorization.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office. This Privacy Policy describes these uses and disclosures in detail.

I _____, hereby authorize Los Gatos Eye Care to use and disclose health information related to my personal health, treatment or payment for treatment.

FINANCIAL AGREEMENT

The undersigned, whether signing as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates and terms of Los Gatos Eye Care. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Los Gatos Eye Care. I also authorize Los Gatos Eye Care to release any information required for payment to be made. **If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balance.**

My signature below verifies that I understand this agreement and the above financial disclaimers. _____

Initials

CONTACT LENS FEES

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are established according to the complexity of the case and the estimated time necessary to care for the individual patient.

Fees for contact lens assessment services start at $97.00. As with glasses, contact lens materials are an additional fee. My signature below verifies I understand the contact lens fees.

REFRACTION FEE

The part of your evaluation that determines your prescription is called refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP and EyeMed, your refraction is included with your exam benefits. Most medical insurance carriers (including Medicare), do not cover a refraction. The fee for a refraction is $73.00.*** My signature below verifies I understand the refraction fee.

RETINAL IMAGING

As part of our preventative health care package we include digital images of the retina and optic nerve. Such images are very valuable in the early detection and/or diagnosis (ie glaucoma, macular degeneration, diabetic retinopathy, hypertensive retinopathy). **The fee for retinal imaging $39.00.** In some cases, the fees may be covered by your Medical Insurance. My signature below verifies I understand the retinal imaging fee. _____

Initials

_____

Patient (parent/guardian) Signature Date

PATIENT'S GUIDELINES AND EXPECTATIONS

At Los Gatos Eye Care (LGEC) we spend extra time getting to know our patients in a professional, relaxing and positive environment. Our goal at LGEC is to provide top quality care to our patients in a compassionate and professional environment. We do our best to stay on time with our schedule and give you our undivided attention.

As a patient of LGEC, we ask that you review the guidelines and expectations of the practice which help us give you the best and most timely care possible.

1. If you are unable to keep an appointment, kindly call our office 48 hours prior to your appointment. We can then reschedule your appointment to a more convenient time.

2. A $25.00 fee will be applied to all appointments canceled within a 24 hour period or if you fail to keep your appointment.

3. It is important to have all registration forms completed prior to your examination. If the forms are not complete at the time of your appointment, or you are late to your appointment, you may need to be rescheduled for a later date.

4. Co-pays and any other balance must be paid at the time of your service.

5. There is a $25.00 banking fee for all returned checks. This sum is used to offset the fees incurred by Los Gatos Eye Care from our financial institution. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order, or credit card.

6. Los Gatos Eye Care will send you a statement after your insurers have been billed and your insurers have considered your charges. If no payment is received after 90 days, your account may be turned over to a collections agency and a $25.00 late payment/pre-collection fee will be added to your account to offset the administrative costs incurred when accounts are assigned for collection.

7. Los Gatos Eye Care is NOT a party to any divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minor rests with the accompanying adult.

8. The adult accompanying a minor and the parents (guardians) of the minor are responsible for full payment for services rendered to the minor patient. For unaccompanied minors, non-emergent or treatments unrelated to an ongoing care plan will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service has been obtained or verified.

9. If you have recently moved, had a change to your insurance, please supply us with the new information.

10. You are responsible for knowing the coverage and benefits of your particular insurance company. ***Verification of eligibility is done as a courtesy only and is not a guarantee of payment.*** You are responsible for any remaining balance after we bill your insurance, whether it is for glasses, contact lenses, examinations or other professional services and tests.

11. It is understood and agreed that Los Gatos Eye Care maintains a safe environment for personal belongings. LGEC shall not be liable for the loss or damage to any money, jewelry, glasses, documents, clothing, electronic devices or other personal articles of unusual value.

12. We are happy to provide a copy of your medical records upon a request in writing. First complete and sign a Release of Records form authorizing us to release your records. We cannot begin the process without this documentation. There is a charge for copying medical records. There is a fee of .25 cents per page copied, plus reasonable clerical fees of $24.00/hour (charged in quarter hour increments), which includes the time spent in locating, acquiring, and copying the actual records plus postage fees. The records will not be sent until the fee is paid. These fees are set by the State of California (Health & Safety Code section 123110), not Los Gatos Eye care.

13. There is no charge for uncomplicated forms completed as part of an office visit (ex: Day Camp waiver for a child). If additional attention is needed, there may be a charge for completing the form based off your medical records. You will be informed of the cost prior to completing, so an informed decision can be made by you.

_____ _____

Patient (parent/guardian) Signature Date

Insurance and Fees Collection

We will attempt to bill whichever insurance you have advised us of as a courtesy. Please understand that insurance reimbursement can be a long and difficult process for medical providers AND patients. There are instances when insurers will stall, deny, pend, spend weeks and months reviewing claims, and then reduce or deny any reimbursement officered. Our billing staff has undergone extensive training to maximize your insurance reimbursement while reducing the time in which they pay.

Non-Contracted indemnity insurance plans/No insurance card

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services in advance. Please note that not all insurers agree to contract with us. In the event that your insurance does not reimburse us within ninety (90) days, we will transfer this balance to you as your responsibility and send you a statement. We are NOT Medi-Cal providers, and do not accept Medi-Cal. We do not accept any other State's Medicaid programs.

Know Your Plan Benefits- Non Covered Services are Your Responsibility

Each and every insurance company and plan, including Vision Plans, has different plans, each with different benefits***. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan***. Your insurer can assist you with any questions you have relative to your own benefits with them. Co-payments are due at the time of service. We may decline to see patients for non-emergent visits if co-payments are not made at the time of the visit. Your physician may provide services that may not be covered as a benefit of your specific plan with your insurer.

Patients or Guarantors are financially responsible for any and all services and materials (glasses, contact lenses and neutraceuticals) provided that may not be covered by your insurance plan.

PPO Plans

As a contracted provider, Los Gatos Eye Care has agreed to accept a discounted rate from your plan for covered services, however all co-payments, co-insurance, and/or deductibles are your responsibility.

Vision Plans (VSP and EyeMed)

As a contracted provider, Los Gatos Eye Care has agreed to accept a discounted rate from your plan for covered services and materials (glasses and contact lenses/services). ***Although we attempt to calculate all material and exam overages in the office, at times there are other fees patients will owe after the insurance explanation of benefits is received. It is your responsibility to pay these fees, even after you have already received your glasses and/or contact lenses.***

Medicare

As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible co-pays and refraction fee. We must collect this. We will be happy to bill any secondary (or tertiary) insurance you may have once we have been informed that you have such coverage in effect. If any balance remains once Medicare and these insurers have processed our claims, we will transfer responsibility of payment to you, and send you a statement.

Important reminder for Medicare enrollees: If you qualified for Medicare coverage and decided to enroll in a Medicare+Choice/Medicare Advantage plan (e.g. Secure Horizons, Blue Cross Senior Secure, SCAN) you may need to first get a referral from your Primary Care Physician (PCP) before a visit to Los Gatos Eye Care will be covered. Please call the number on your new insurance card for information from that plan.

Medicare enrollees with "original" Medicare coverage can be seen at Los Gatos Eye Care without a referral.

Secondary Insurers

Having more than one insurance does NOT necessarily mean that your services are covered 100%.

Depending on your plan's benefits, the secondary insurers will pay as a function of what your primary insurer pays. We will bill your secondary insurer as a courtesy. You are responsible for any balances after your insurers have processed our claims.

My signature below verifies I understand all insurance and fees collection policies of LGEC.

_____ _____

Patient (parent/guardian) Signature Date

Los Gatos Eye Care

15563 Union Avenue, Los Gatos, CA 95032 Phone 408-377-2020 Fax 408-377-2022

SIGNATURE ON FILE

NAME OF INSURED

_____

Last **First**

NAME OF PATIENT

_____

Last **First**

(If other than insured)

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Dr. Ilene Polhemus O.D., Dr. Barbora Bell O.D., or Dr. Johanna Poon O.D. for any services rendered to me by Dr. Ilene Polhemus O.D., Dr. Barbora Bell O.D., or Dr. Johanna Poon O.D..

I authorize the release of all medical information to the insured's health insurance carrier that is:1) acquired in the course of my examination or treatment and 2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Ilene Polhemus O.D., or any of her authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

_____ _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE **DATE**

Receipt of Notice of Privacy Policies & Consent Form

Los Gatos Eye Care
15563 Union Avenue
Phone 408-377-2020
Fax 408-377-2022

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office **(or from our website)**.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations. I acknowledge that I have received the *Notice of Privacy Practices* from Los Gatos Eye Care.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____