Northern California Cornea Associates

CONSULTANTS IN DISEASES AND SURGERY OF THE CORNEA AND EXTERNAL EYE

DAVID R. DEMARTINI, MD   MIRA LIM, MD   ENOCH NAM, MD

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122 La Casa Via, Suite 222
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Phone: (925) 947-0888
Fax: (925) 947-4385

- **Payment and Billing Policy:**

  Please provide us with your current information and inform us of any changes as soon as possible. If your insurance has changed, please provide with your new insurance card (front and back). If the insurance billing address is different than what is listed on the card, you are responsible for informing us of the correct location to send claim forms.

- **Insurance Information:**

  Your insurance will be billed and you will be responsible for any co-payments, co-insurance, deductibles, remaining balance and non-covered services.

  Authorizations/ Referral:

  If you have an HMO plan, you are responsible for obtaining an authorization or referral for your initial office visit. Without a prior authorization or referral, you will be expected to **pay out-of-pocket** for the examination at the time of service. If you change your primary care physician, you will be responsible for obtaining a new authorization or referral from your new physician.

  Please have your copayment and any outstanding payments ready at the time of service. There is a $20.00 processing fee for unpaid copayments and balances. For returned checks, there is a $30.00 fee. We accept the following methods of payment: CASH, CHECK, DISCOVER, VISA, AND MASTERCARD.

- **Other Insurances:** We are **not** providers for any vision insurances, **except** for Medical Eye Services, with Dr. Lina Chan, OD. We will not be accepting assignment on your vision coverage therefore adjustments will not be made for any reimbursements for contact lenses, contact lens prescription and frames. Payment will be expected to be **pay out-of-pocket** at the time of service.

- **Cancellation Fee:** We require a **24-HOUR NOTICE** for appointment cancellations. A charge of $50.00 will be billed to your account without this notification. If you are unable to abide by our appointment policy, you may be dismissed from our office.

I have read the above information and hereby agree to these terms.

Signature: ____ Date:__________________

PATIENT INFORMATION

Name: ____

Address: ______________________________________ City:____________________ State: _____ Zip:__________

Date-of-birth: ___________________ Social Security #: _________________________ Gender: M F

Home Phone: ( ) _____________ Cell Phone: ( ) ______________ Work Phone: ( ) _______________

Email:______________________________ Occupation: _________________________

Primary Care Physician: ______________________________________ Phone: ( ) ______________________

Guarantor/Responsible Party (if other than self):

Name: ___________________________ Date-of-birth: ________________ Relationship: ___________________

Address: ____

City: ______________________ State: _______ Zip: __________ Home Phone: ( ) ____________________

Emergency Contact Information:

Name: _________________________ Relationship: _______________ Phone: ( )_____________________

PRIMARY INSURANCE: _________________________ Are you the primary subscriber? Y / N If NO, Relationship to the primary subscriber: ____________ Date of birth of primary subscriber: _________________	**SECONDARY INSURANCE:** ______________________ Are you the primary subscriber? Y / N If NO, Relationship to the primary subscriber: ____________ Date of birth of primary subscriber: _________________

WORKMAN'S COMP: _____________________________ **DATE OF INJURY**: _______/________/__________

REFERRAL INFORMATION:

Referred by: ___________________________ Family / Relative: __________________ Friend :__________________

If Self: ○ Website ○ Yelp ○ Health Insurance ○ Other: ____________________

PHARMACY INFORMATION

Name, street, city, and state of your current pharmacy: ____

____

STATISTICAL INFORMATION	The questions below are for statistical information only and your responses will remain completely confidential. We are required to ask these questions.

What is your race?

Are you Hispanic/Latino? Y / N

- ❏ Caucasian
- ❏ American Indian or Alaska Native
- ❏ Asian
- ❏ African American
- ❏ Native Hawaiian or Pacific Islander
- ❏ Other/Decline to State
- ❏ What language do you prefer to speak? ____________________

I hereby give authorization for payment of insurance benefits to be made directly to NORTHERN CALIFORNIA CORNEA ASSOCIATES, INC., and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: ____ Date: _______________________

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL HISTORY

Select any of the following medical conditions that you currently have:

- ❏ Anxiety
- ❏ Arthritis
- ❏ Asthma
- ❏ Atrial Fibrillation (Irregular Heartbeat)
- ❏ Bone Marrow Transplantation
- ❏ BPH (Enlarged Prostate)
- ❏ Breast Cancer
- ❏ Colon Cancer
- ❏ Chronic Obstructive Pulmonary Disease
- ❏ Coronary Artery Disease
- ❏ Depression
- ❏ Diabetes–**Last hemoglobin A1C:_____**
- ❏ End State Renal Disease
- ❏ Gastro Esophageal Reflux Disease
- ❏ Hearing loss
- ❏ Hepatitis–If yes, please specify:______
- ❏ Hypertension
- ❏ HIV/AIDS
- ❏ Hypercholesterolemia
- ❏ Hyperthyroidism
- ❏ Hypothyroidism
- ❏ Leukemia
- ❏ Lung Cancer
- ❏ Lymphoma
- ❏ Prostate Cancer
- ❏ Radiation treatment
- ❏ Seizures
- ❏ Stroke
- ❏ Other:___________________________

PAST SURGERIES

Have you had any past surgeries? *If yes, please list the type of surgery, the operated body part, and date of surgery:*

____

____

OCULAR HISTORY

Date of last eye exam: _______________

Do you have any of the following eye conditions, or have you had them in the past?

- ❏ Blepharitis (inflammation of the eyelids)
- ❏ Cataracts
- ❏ Glaucoma
- ❏ Macular Degeneration
- ❏ Narrow Angles
- ❏ Ophthalmic migraines
- ❏ Strabismus (lazy eye)
- ❏ Other:________________________

PAST OCULAR SURGERIES

have you had any past eye surgeries? *If yes, please list the type of surgery, the operated eye, and date of surgery:*

____

____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following problems?

- ❏ Eye pain
- ❏ Vision changes
- ❏ Headache
- ❏ Abdominal pain
- ❏ Abnormal bleeding
- ❏ Anxiety
- ❏ Chest Pain
- ❏ Hearing loss
- ❏ Joint Pain
- ❏ Rashes
- ❏ Shortness of breath
- ❏ Unintended Weight loss

MEDICATIONS

Please list the names of all prescription and over-the-counter medications you are currently taking, including any eye medications (or provide us with a current list that we can photocopy):

____

____

____

____

ALLERGIES

Do you have allergies to any medications? **YES** **NO**
If yes, please indicate the name of the medication and the associated reaction(s).

______________________________ ______________________________________

______________________________ ______________________________________

______________________________ ______________________________________

______________________________ ______________________________________

SOCIAL HISTORY

Do you currently smoke? **YES** **NO** – *If yes, how often?* _______________ *# of years*: _____

Are you a former smoker? **YES** **NO**

Do you drink alcohol? **YES** **NO** – *If yes, how much daily?* ________________________

FAMILY HISTORY- Immediate family members only (parent, sibling, child). Please specify **which family member** has/had this condition?

Blindness: _____________

Cataracts: _____________

Glaucoma: _____________

Macular Degeneration: ___________

Retinal Detachment: ____________

Cancer: _____________

Diabetes: ____________

Heart Disease: ____________

Hypertension: ____________

CVA (Stroke): _____________

Other: ___________

VACCINATIONS

Date of last influenza vaccination: ___________ Date of last pneumonia vaccination: ____________

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NON-COVERED SERVICES

1. **Office Formulated Antibiotics: $50**
   We commonly prescribe the following antibiotics for eye infections: Gentamycin, Vancomycin, Ancef, and Tobramycin. Since these medications have such a short shelf-life they are not readily available in local pharmacies. Should you need any of these medications, we can make this in the office at $50/bottle. **We DO NOT bill insurance for OFFICE FORMULATED ANTIBIOTICS**. If you choose to get these antibiotics elsewhere, the nearest compounding pharmacies that dispense these medicines are:

   Wellspring Compounding Pharmacy in Berkeley = $95 AND UP
   (510) 548-8777

   Leiter's Pharmacy in San Jose = $100 AND UP
   (408) 292-677

2. **Examination for eyeglasses: $75**
   Please be informed that an examination for eyeglasses or vision prescription, formally known as refraction, is considered a "NON-COVERED SERVICE" by Medicare and many other insurance companies.

3. **Contact Lenses AND Contact Lens Fitting: $100 AND UP**
   We are not providers for any vision insurance. Furthermore, our optometrists are not contracted providers for any medical insurance companies. We cannot bill any vision or medical insurance for these services. For these reasons, we require payment in **FULL** at the *TIME OF SERVICE*.

   If you wish to seek payment from your insurance on your own, we are happy to provide you with an itemized bill to obtain reimbursement. **However, the office is not responsible for contacting insurance companies to pursue authorization or payment.**

4. **Department of Motor Vehicles (DMV) Form AND Other Forms: $15**
   To complete the necessary forms for the DMV, you will need to schedule an appointment with one of our optometrists (DMV requires a current **refraction** and if needed an additional $75 will be assessed). This includes any forms that needs to be filled out by doctor including **disability**.

Signing below means that you have received and understand that any of these services are ever necessary or requested, you agree to be financially responsible for payment at the time of these services.

_______________________________________ ____________________

Patient Signature Date

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, herbal remedies, or other undisclosed drugs that patients take on their own may not be included.

<u>You have the option to give permission to your healthcare provider, your pharmacy, and your health insurer to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.</u>

<u>PLEASE CHECK ONE:</u>

- ❏ I **DO** give permission to allow NORTHERN CALIFORNIA CORNEA ASSOCIATES to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

- ❏ I **DO NOT** give permission to NORTHERN CALIFORNIA CORNEA ASSOCIATES to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signing below means that you have received and understand this consent form.

Patient Signature: ____________________________________ Date: _________________

Patient Name(PRINT): ____________________________

Relationship to Patient, if other than patient’s signature: ______________________________

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NOTICE OF PRIVACY ACKNOWLEDGEMENT

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 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 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient Signature: ___________________________________ Date: ________________

Patient Name (PRINT) : ___________________________

Relationship to Patient, if other than patient’s signature: _____________________________