Welcome to Eye Care Center of Napa Valley

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Dear:

Welcome to Eye Care Center of Napa Valley. We are dedicated to serving our patients and will provide you with the most comprehensive and modern care.

Your appointment is scheduled with Dr _____

On _____ **at** _____ **a.m./p.m.**

If your visit is for an annual eye exam, it is the standard of care to dilate your pupils. This will cause your eyes to be light sensitive, and some patients may have difficulty with their vision. We will provide dark wrap-around eye protection for you when you leave the office. However, you may wish to arrange for someone else to drive you home.

To assist us in serving you, please make sure you bring the following:

- The attached forms completed and signed.
- Medical insurance cards and vision plan coverage information.
- Bring all medications and eye drops being used to show your doctor.
- All glasses and contacts currently being used.
- If you are a first time patient with soft contacts, please bring the containers listing the parameters, or an old contact lens prescription.
- Attention contact lens wearers: a separate contact lens evaluation will be assessed to ensure a proper fit of your lenses and to evaluate your vision with the contacts. A separate contact lens exam and fitting fee may be necessary and will be discussed with your doctor at the time of your exam. This may not be covered by your insurance carrier.
- Referral from your primary care physician, if your insurance requires one. If you do not receive it, please call the office, prior to your appointment, to see if the referral was sent here. This applies to some HMO's and Medi-Cal coverage.
- Insurance co-payment.
- Medicare patients: Responsible for deductible (if not met), $50 payment for refraction fee (not covered by Medicare).

Sincerely,

Please visit www.napaeye.com for more information.

Patient Information Sheet

Name:_____ Date:_____

Address:_____

Date of Birth:_____ SS#: _____

Sex: ☐ Male ☐ Female

Phone Numbers:
Home:_____ Work:_____ Cell:_____

Email:_____

Primary Language:_____ Employer: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer

Insurance

Vision Insurance:_____ ID #:_____

Insured's Name:_____ Group #: _____

Insured's DOB:_____ Relationship to Insured:_____

Primary Medical Insurance:_____ ID#:_____

Insured's Name:_____ Group #: _____

Insured's DOB:_____ Relationship to Insured:_____

Secondary Medical Insurance:_____ ID#:_____

Insured's Name:_____ Group #: _____

Insured's DOB:_____ Relationship to Insured:_____

Emergency Contact

Name:_____

Address:_____

Phone:_____

Relationship:_____

Patient Information Sheet

FINANCIAL POLICY

INSURANCE BILLING

We will gladly bill your insurance for services provided in this office; however, we do need your help. It is impossible for us to know the terms and conditions of every insurance policy.

1. Please make sure we are given a copy of your most recent insurance card. Many companies have/are changing identification numbers.

2. Please make all copays at time of service.

3. KNOW YOUR COVERAGE! You should know the amount of your co-pay, the amount of your deductible, and any limitations or exceptions set in your coverage. If you have questions about your plan, the best source for answers is the 800 number on your card. If any claim we send to your insurance company is denied, you are responsible for payment.

Initial ____

WHAT HAPPENS IF I FORGET MY INSURANCE CARD?

We will bill your insurance carrier if you can provide all of the necessary information needed for billing. If you are unable to provide your insurance card, you will be considered private pay.

Initial _____

WHAT HAPPENS IF I DO NOT HAVE A REFERRAL FROM MY PRIMARY CARE PHYSICIAN?

You are responsible for contacting your primary care doctor to obtain a referral. You are financially responsible for all services performed, whether or not a referral is presented.

Initial ____

Patient Information Sheet

EYE REFRACTION

Refraction is the process of determining the optimal eyeglass prescription for your eyes. It enables us to provide glasses but MORE IMPORTANTLY, to determine how well you can see. We need the information to distinguish vision problems caused by poor focus (correct by glasses or contact lenses) from problems caused by eye disease.

A refraction may or may not be performed at the time of your visit, depending on our doctors' judgment of its necessity. **Medicare and many insurance companies do not provide this service as a benefit.** When it is performed there will be a fee of $50 that the receptionist will request at the end of your visit.

Initial ___

FINANCIAL POLICY AGREEMENT

General Medical Consent:

The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures and medical services rendered to the patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his or her attending physician.

Initial ___

Release of Information:

To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, Eye care Center, may disclose portions of the patient's medical record and account file to any person or corporation which may be liable for all or any portion of the patient's charges including but not limited to insurance companies, health care service plans or worker's compensation carriers.

Initial ___

Patient Information Sheet

Assignment of Insurance Benefits:

I authorize Eye Care Center, to file insurance claims on my behalf for services rendered and authorize payment directly to Eye Care Center of any benefits both basic and major medical otherwise payable to or on behalf of the patient for all services rendered.

Initial ___

- I have read and understand the office policy on refraction, and understand that this policy will apply to all my future visits.
- I have read the financial policy and I understand that I am financially responsible for all charges whether or not paid by my insurance.
- By my signature below, I acknowledge that I have received Eye Care Center of Napa Valley's Notice of Privacy Practices.

_____

Signature of patient or responsible party Date:

_____

Print patient's name or responsible party

Medical and Vision Insurance

The doctors of the Eye Care Center of Napa Valley provide both **medical** and **vision** services. Your exam findings and diagnosis today will determine if your medical or vision plan will be billed.

The term "vision insurance" is commonly used to describe wellness plans designed to reduce your costs for routine preventative eye care, (eye exam), and prescription eyewear, glasses or contact lenses.

When your diagnosis becomes a **medical diagnosis, not** a vision diagnosis, the scope of your visit will also change and your eye care physician will concentrate on the immediate eye health issue. Because of this change, your visit to our office for that day **will be billed to your medical insurance.**

If this happens, your routine vision exam to determine your eyeglass prescription will be rescheduled for a different time and your vision benefits will be used for that appointment and any glasses or contacts ordered.

I agree that my **medical insurance will be billed** if my doctor determines I have a medical diagnosis. I also understand that my vision plan can be used at a later date to determine my eyeglass or contact lens prescription and for any contacts or glasses purchase.

Patient Signature: _____

Date: _____

Patient Payment Policy

Thank you for choosing us as your specialty health care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance.
We participate in most insurance plans, including Medicare. If you are not insured by a health insurance plan that we do business with, payment in full is expected at each visit. If you are insured by a health insurance plan that we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles.
All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit

3. Non-covered services.
Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. *A refraction is not covered by most medical insurances.*

4. **Proof of insurance.**
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission.
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information
directly. It is your responsibility to comply with their request.

Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Patient Payment Policy

6. Coverage changes.
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment.
If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments.
Our policy is to charge Forty Dollars ($40.00) for missed appointments not canceled within a reasonable amount of time (24 hours in advance). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or responsible party Date

_____

Print of patient's name or responsible party

Medical History Questionnaire

Today's Date: _____

Name: _____ Date of Birth: _____

Date of Last Eye Exam: _____ Last Eye Exam By: _____

Do you currently wear: ☐ Glasses ☐ Contacts ☐ Both

Are you interested in learning about All Laser Lasik: ☐ Yes ☐ No

Occupation: _____ Hobbies: _____

Primary Care Provider: _____

Referral Source: _____ ☐ Self

List any medications you currently take: _____

_____

Do you have any allergies to any medications: _____

If YES, list medications: _____

List ALL surgeries you have had (including non-eye related): _____

_____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you received the influenza immunization in the last 12 months? ☐ Yes ☐ No

Do you currently have any problems in the following areas? ☐ Yes ☐ No

General/Constitution: ☐ None ☐ Unintentional Weight Loss ☐ Fever ☐ Fatigue

Cardiovascular: ☐ None ☐ Chest Pain

Ears, Nose, Mouth, Throat: ☐ None ☐ Sinus Pressure ☐ Jaw Pain/Fatigue ☐ Cold Sores ☐ Oral Ulcers

Respiratory: ☐ None ☐ Wheezing ☐ Cough ☐ Snoring ☐ Shortness of Breath

Gastrointestinal: ☐ None ☐ Difficulty Swallowing ☐ Abdominal Pain

Genitourinary: ☐ None ☐ Frequent Urination ☐ Discharge

Musculoskeletal: ☐ None ☐ Joint Stiffness ☐ Back Pain

Integumentary/Skin: ☐ None ☐ Rash ☐ Blisters

Neurological: ☐ None ☐ Headache ☐ Numbness ☐ Weakness

Psychiatric: ☐ None ☐ Depression ☐ Anxiety

Endocrine: ☐ None ☐ Excessive Urination ☐ Excessive Thirst

Hematologic/Lymphatic: ☐ None ☐ Prolonged Bleeding ☐ Easy Bruising

Allergic/Immunologic: ☐ None ☐ Itchy Eye/Nose ☐ Runny Nose ☐ Sneezing

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per day? _____

Do you smoke? ☐ Yes ☐ No If yes, How many packs a day? _____ How many years? _____

Do you use any illicit drugs? ☐ Yes ☐ No If yes, when and what drug? _____

Medical History Questionnaire

Past Eye History

Have you or anyone in your family had any of the following eye problems?

Cataracts:	☐ Yes	☐ No	Relationship: _____
Diabetic Retinopathy:	☐ Yes	☐ No	Relationship: _____
Dry Eyes:	☐ Yes	☐ No	Relationship: _____
Eye Injury:	☐ Yes	☐ No	Relationship: _____
Eye Turn:	☐ Yes	☐ No	Relationship: _____
Glaucoma:	☐ Yes	☐ No	Relationship: _____
Keratoconus:	☐ Yes	☐ No	Relationship: _____
Lazy Eye or History of Patching as a Child:	☐ Yes	☐ No	Relationship: _____
Macular Degeneration:	☐ Yes	☐ No	Relationship: _____
Posterior Vitreous Detachment:	☐ Yes	☐ No	Relationship: _____
Retinal Detachment/Retinal Tear:	☐ Yes	☐ No	Relationship: _____

Other: _____

Past Medical History

Have you or anyone in your family had any of he following?

Anemia:	☐ Yes	☐ No	Relationship: _____
Asthma:	☐ Yes	☐ No	Relationship: _____
Cancer:	☐ Yes	☐ No	Relationship: _____
Cold Sores:	☐ Yes	☐ No	Relationship: _____
Congestive Heart Failure:	☐ Yes	☐ No	Relationship: _____
COPD:	☐ Yes	☐ No	Relationship: _____
Diabetes:	☐ Yes	☐ No	Relationship: _____
Heart Disease:	☐ Yes	☐ No	Relationship: _____
High Blood Pressure:	☐ Yes	☐ No	Relationship: _____
High Cholesterol:	☐ Yes	☐ No	Relationship: _____
Lupus:	☐ Yes	☐ No	Relationship: _____
Migraines:	☐ Yes	☐ No	Relationship: _____
Plaquenil Use:	☐ Yes	☐ No	Relationship: _____
Dosage: _____			Duration: _____
Rheumatoid Arthritis:	☐ Yes	☐ No	Relationship: _____
Shingles:	☐ Yes	☐ No	Relationship: _____
Sleep Apnea:	☐ Yes	☐ No	Relationship: _____
Thyroid Dysfunction:	☐ Yes	☐ No	Relationship: _____

Other: _____