Cataract Patient Packet

MarinEyes
901 E Street
San Rafael CA 9490
Tel: 415-454–5565

MarinEyes
165 Rowland Way, Suite 207
Novato, CA 94945
Tel: 415-892-0111

PATIENT INFORMATION					
NAME (Last) (First) (Middle)		BIRTHDATE	SSN#	SEX	EMAIL
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if applicable)			HOME PHONE
CITY STATE ZIP CODE	HOME PHONE	CITY STATE ZIP CODE			
PRIMARY CARE PHYSICIAN	CELL PHONE	REFERRING PHYSICIAN			
PRIMARY EYECARE PROVIDER (OPTOMETRIST)		PHARMACY		PHARMACY PHONE	
EMERGENCY CONTACT	HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT		

EMPLOYER	
PRIMARY EMPLOYER	SECONDARY EMPLOYER (if applicable)
ADDRESS	ADDRESS
CITY STATE ZIP CODE	CITY STATE ZIP CODE
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (IF Different than above)				
NAME (Last, First, Middle)	RELATION TO PATIENT	BIRTHDATE	SSN#	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if applicable)		
CITY STATE ZIP CODE		CITY STATE ZIP CODE		
HOME PHONE		HOME PHONE		

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY STATE ZIP CODE		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY STATE ZIP CODE		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Benefit Assignment & Acknowledgment of Financial Responsibility

I authorize the above named insurance companies to make payment directly to MarinEyes for medical services rendered.
I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles, refractions and any other charges my insurance company deems my responsibility. In the event my account should become delinquent for a period of thirty days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and/or attorney fees.

SIGNATURE OF PATIENT/GUARDIAN **DATE**

MARIN OPHTHALMIC CONSULTANTS
CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name:_______________________________________ **Date of Birth:**_____________ **Date:**______________________

Do you currently have any problems in the following areas? Please mark **YES** or **NO.**

EYES:	YES	NO
Vision problems	☐	☐
Double Vision	☐	☐
Light or Glare sensitivity	☐	☐
Flashing Lights	☐	☐
Floaters	☐	☐
Eye pain or Irritation	☐	☐
Discharge	☐	☐
Redness	☐	☐
Prior LASIK or PRK	☐	☐

Other eye Surgery: ______________________________

____

Previous Eye Disease: ___________________________

____

NEUROLOGICAL:	YES	NO
Headaches	☐	☐
Migraine	☐	☐
Stroke	☐	☐

Other: ______________________________

EARS, NOSE, MOUTH, THROAT:	YES	NO
Hearing Problems	☐	☐
Sinus	☐	☐
Mouth or Lip Sores	☐	☐
MUSCULOSKELETAL:		
Arthritis, type______________	☐	☐
Tendonitis	☐	☐
Rheumatoid Disease	☐	☐
RESPIRATORY:		
Breathing Problems	☐	☐
Asthma	☐	☐
Chronic cough	☐	☐
COPD	☐	☐
Tuberculosis	☐	☐
CARDIOVASCULAR:		
High Blood Pressure	☐	☐
Arrhythmia	☐	☐
Blocked Arteries or Veins	☐	☐
Heart Problems	☐	☐
GASTROINTESTINAL:		
Digestive Problems	☐	☐
Hepatitis	☐	☐

GENITOURINARY:	YES	NO
Prostate Problems	☐	☐
Urinary Infection	☐	☐
History of Prostate Meds (Flomax)	☐	☐
INTEGUMENTARY:		
Rashes	☐	☐
Rosacea	☐	☐
Skin Cancer	☐	☐
HEMATOLOGICAL / LYMPHATIC:		
Anemia	☐	☐
Leukemia	☐	☐
Lymphoma	☐	☐
Slow clotting time	☐	☐
Excessive Clotting	☐	☐
ALLERGIC AND IMMUNOLOGIC:		
Hay fever	☐	☐
Asthma	☐	☐
Sinus Problems	☐	☐
Seasonal Allergies	☐	☐
ENDOCRINE:		
Diabetes	☐	☐
Thyroid disorder	☐	☐

Other: ___________________________________

CONSTITUTIONAL:	YES	NO
Cancer	☐	☐
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐
HIV Positive	☐	☐
PSYCHIATRIC:		
Depression	☐	☐
Psychiatric Meds	☐	☐
Alcohol or Substance Abuse	☐	☐
WOMENS HEALTH:		
Pregnant or nursing	☐	☐

DRUG ALLERGIES: **NO** **YES**

LIST: ____

____

____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

MEDICATIONS

NAME OF MEDICATION	DISEASE OR CONDITION	DOSAGE & FREQUENCY

SURGERIES

PART OF BODY	DISEASE OR CONDITION	DATE

COMMENTS:

_____

_____

_____

_____

_____

Name:________________________ Date:______________________

DOB: ________________________

Cataract Patient Visual Lifestyle Questionnaire

MarinEyes' mission is to provide you with the highest quality, personalized eye care available. In order to do so, answering the following questions will help us determine how best to treat and improve your vision.

Who referred you to us? Physician?______________ Optometrist?_____________ Friend?______________

Would you like to know about ……………… ❑ **Cataract Surgery** ❑ **Lens choices for cataracts**

Are you currently: (please check all that apply)

❑ Retired ❑ Homemaker ❑ Student ❑ Employed/Occupation:__________________________________

If Cataract Surgery is recommended, would you like to reduce your dependency on glasses? YES NO

If you had to wear glasses after surgery, would you prefer:
❑ **DISTANCE** ❑ **MID-RANGE** ❑ **NEAR VISION** ❑ **I PREFER NO GLASSES**

If you could have good distance and near vision without glasses but the compromise might be halos at night, would you be okay with that? YES NO

Please describe your need for night vision:
❑ **Very important** ❑ **I want to drive comfortably but don't mind halos** ❑ **I don't drive at night**

How many hours a day spent on ___Cell Phone ___Reading ___Computer ___Driving

Does glare bother you? ❑ **NO** ❑ **YES, sunlight** ❑ **YES, nighttime**

Do you wear/need protective eyewear for work? YES NO

Circle your Hobbies or Work:

Reading Card/board games Yard work Golfing Water sports Beach

Needlecraft Painting Power tools Walking/Running Horseback/Bike Other Sports

Model making Playing musical instrument Home workshop Hunting/Shooting Boating/Fishing

Other:

How would you describe yourself? ❑ **Easy going** ❑ **Medium** ❑ **Perfectionist**

Thank you for completing this survey and allowing us to serve you better

Revised - 02/2012

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a comprehensive eye examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our HIPAA Compliance Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

MarinEyes

901 E Street, San Rafael, CA 94901 - Tel: 415-454-5565
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("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 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 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 health care operations. I also understand 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 Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

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

Date: ______________________________

Initials: ______________________________

Reason: ______________________________

____

MarinEyes

Marin Ophthalmic Consultants

****TO ALL PATIENTS**

It is important that complete and accurate insurance billing information is provided to our office, such as your and/or your subscriber's health insurance carrier, vision plan, social security number, date of birth and valid driver's license or ID. It is the patients' responsibility to know their own plans limitations & covered services and referral / authorization policies.

Benefit Assignment and Acknowledgement of Financial Responsibility

I authorize my listed insurance companies to make payment directly to MarinEyes for medical services. I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles, refractions and any other charges my insurance company deems my responsibility. Should my account become delinquent for a period of thirty (30) days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and / or attorney fees.

****PRIVATE PAY PATIENTS (NO INSURANCE)**

Private pay patients are responsible for all charges incurred. Payment is required at the time of your service. Private pay patients include those who do not provide their social security number, date of birth, necessary referrals and authorizations or accurate and complete insurance information.

****HMO/PPO/POS PATIENTS**

HMO/PPO/POS patients are responsible for following the guidelines and understanding the limitations of their own insurance coverage. Many plans have a <u>strict</u> <u>referral</u> and <u>preauthorization</u> process, which must be closely followed. If you have one of these plans and you do not provide us with the necessary referrals and/or authorizations, you may be held financially responsible for any charges incurred. Note: It is your responsibility to bill secondary insurance if you have an HMO, PPO or POS as your first insurance.

****MEDICARE PATIENTS**

We are participating providers in the Medicare program. Provided we have the correct billing information, we will bill your secondary insurance as a courtesy. We bill secondary insurance only **ONCE** unless Medicare forwards it automatically. Medicare patients are responsible for paying deductibles and any balance due.

****MEDI-CAL AND MEDI-CAL PENDING PATIENTS**

Medi-cal patients must present proof of eligibility prior to or at the time of service. Payment is required at time of service for Medi-cal pending patients and Medical patients with a share of cost.

****WORKMAN'S COMPENSATION CLAIMS**

Patients are required to provide case number, name and phone number of case worker and complete Worker's Compensation Insurance Carrier information as well as name, address and phone number of employer. Patients who do not have complete information will be considered private pay at the time of visit.

****NOTICE OF NON-COVERED SERVICES**

Complete Eye Exams with our Physicians include a ***Refraction*** with an Optometrist. This test is **<u>not</u>** covered by Medicare and most other insurance carriers, in which case the charge is the responsibility of the patient.
The charge for this ***Refraction*** is $55.00. A ***Refraction*** is a test to determine your glasses prescription. Your Doctor advises that you have this test to determine your visual acuity and the general health of your eye as part of your complete examination.

❑ Please check box and place initials where indicated only if you decline the refraction.

Pt initials ____________

SIGNATURE____**DATE:**__________________________