Denny Eye & Laser Center

Kevin Denny, MD Deanna Nguyen, OD Joy Ohara, OD

PATIENT REGISTRATION

NAME: _____ **SEX:** ☐ male ☐ female
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
NO. AND STREET CITY STATE ZIP

(____) _____ (____) _____ (____) _____ _____
HOME PHONE ☐ **WORK PHONE** ☐ **CELL PHONE** ☐ **EMAIL ADDRESS** (for internal use only)

Check the box next to the phone numbers where we may leave a voice mail message in regards to your medical care.

_____ _____ _____ _____
PREFERRED LANGUAGE **SOCIAL SECURITY # (last 4 ssn is ok)** **BIRTHDATE** (MM/DD/YYYY) **AGE**

OCCUPATION: _____ **EMPLOYER:** _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

EMERGENCY/MEDICAL CONTACT: _____
NAME NUMBER RELATIONSHIP

PRIMARY HEALTH INSURANCE

_____
INSURANCE COMPANY NAME COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent) please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

SECONDARY HEALTH INSURANCE

_____
INSURANCE COMPANY NAME COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent) please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

VISION INSURANCE i.e. VSP (Vision Service Plan), EyeMed or MES (Medical Eye Services)

_____
COMPANY COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent) please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 1-800-633.3233 www.mbc.ca.gov

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY STATEMENT

By signing below, I give lifetime authorization for Medicare and/or Insurers to pay Denny Eye & Laser Center on my behalf for services provided to me by Kevin Denny, M.D. or any other person acting as an employee or agent of Dr. Denny. I understand that, regardless of my insurance status, I am ultimately responsible for fees for professional services provided as well as for products furnished through the Denny Eye & Laser Center, particularly for commonly non-covered services such as refraction. I am responsible for deductibles and copayments. Payment of copays is due on the date of service. **Failure to pay copayments and balances at that time will result in an additional billing charge of $10.00**. I agree to pay fees for late-cancelled or missed appointments. I also understand that, should I default on my account, all costs of attorney's fees, interest and/or cost of collections will be my responsibility. I authorize Denny Eye & Laser Center to release all information necessary to secure payments of benefits. I further agree that a photocopy of this agreement shall be valid as the original. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status of the above information.

I ACKNOWLEDGE THAT THIS OFFICE HAS PROVIDED ME WITH NOTICE OF THEIR PRIVACY PRACTICES POLICY

› _____ _____
PATIENT SIGNATURE **DATE**

Patient Reviewed		**OFFICE USE ONLY**

Denny Eye & Laser Center

Dr. Kevin Denny, M.D. Dr. Deanna Nguyen, O.D. Dr. Joy Ohara, O.D.

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____

What brings you in today? _____

GENERAL HEALTH *Please mark all areas of concern regarding your health*

☐ Diabetes	☐ Arthritis	☐ Asthma	☐ Hypertension	☐ High cholesterol	☐ HIV / AIDS
☐ Stroke When?_____	☐ Thyroid / Graves disease	☐ Weight loss/fevers	☐ Heart attack When? _____	☐ Cancer type_____ year _____	
☐ NONE	☐ Other: _____				

EYE HISTORY *Please mark all that apply*

☐ Cataract	☐ Glaucoma	☐ Eye trauma	☐ Strabismus	☐ Amblyopia (lazy eye)
☐ Macular degeneration		☐ Retinal detachment	☐ Dry eye	
☐ NONE		☐ Eye surgery	☐ Other: _____	

FAMILY EYE HISTORY *Please mark all that apply*

☐ Cataract	☐ Glaucoma	☐ Eye trauma	☐ Strabismus	☐ Retinal detachment
☐ Macular degeneration		☐ Eye surgery When? _____	☐ Dry eye	
☐ NONE		☐ Other: _____		

What percent of the time do you wear?	Glasses	☐ Never	☐ 100%	☐ 50%	☐ _____%
	Contact lenses	☐ Never	☐ 100%	☐ 50%	☐ _____%

MEDICATION LIST

Please specify your preferred pharmacy

Name:_____ Address:_____ Phone Number:_____

☐ Separate list provided

Date	Name of medication	Dose / Amount	Reason for use	Date stopped (M/Y)

ALLERGIES

☐ NONE ☐ Penicillin ☐ Codeine ☐ Sulfa

☐ Other: _____

_____

Patient Signature

_____

Date

Patient Reviewed		OFFICE USE ONLY
Date	Patient initials	Office staff initials

SPEED Questionnaire

Name: _____ **Date:** _____

Please fill out the following questionnaire to help us assess your eye care needs. Answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. **Report the type of <u>SYMPTOMS</u> you experience and when they occur:**

Symptoms	At this visit:		Within past 72 hours:		Within past 3 months:	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. **Report the <u>FREQUENCY</u> of your symptoms using the rating list below:**

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

3. **Report the <u>SEVERITY</u> of your symptoms using the rating list below:**

Symptoms	No problems (0)	Tolerable- not perfect, but not uncomfortable (1)	Uncomfortable- irritating, but does not interfere with my day (2)	Bothersome- irritating and interferes with my day (3)	Intolerable- unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

4. **Do you use eye drops for lubrication?** ☐ **YES** **NO** ☐ **yes, how often?** _____

For Office Use Only:
Total SPEED score = _____/28

Denny Eye & Laser Center

NOTICE OF FINANCIAL INTEREST AND YOUR FINANCIAL RESPONSIBILITY

We are committed to providing the best medical care. We also want you to receive your maximum allowable insurance benefits. To meet both goals, we need your partnership and your clear understanding of the following:

1. Your insurance is a unique contract between you and your insurer. WE ARE NOT A PARTY TO THAT CONTRACT. Not all services are covered by all insurance plans. For example, neither a routine eye exam nor refraction is covered under Medicare. "Covered" is not to be confused with the doctor's determination of which services are medically necessary or appropriate, so the doctor may need to perform non-covered services in order to care for you.

2. Please call your insurance company well in advance of your appointment and ask them about your coverage and benefits. Specifically ask what coverage you have for "Routine eye exam" and "Refraction." Our staff cannot possibly know all the details of **your** policy. It is in your best interest to know and understand your benefits, deductible, co-payments, etc. **before** you seek services. We recommend that you record the name of the person with whom you speak, the date, and the phone number called; this provides important documentation if your claim is later denied, or if services are not covered as represented to you. When reviewing your written policy, be sure to review the "Exclusions" page, as services which appear to be covered in the body of the policy may be excluded there.

3. ***Refraction*** is one of the most important parts of your eye exam. This is how we determine whether or not your vision can be improved with eyeglasses. Although it can be essential information to assess many medical problems, it is a non-covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our fee for refraction is **$85.00**, and it is our office policy to collect this fee on the date of service in addition to any copayments your plan may require.

4. Our doctors have a **medical care relationship with you**, separate from any contractual agreements with insurance companies. Because you are the recipient of services, all charges are your responsibility as of the date the services are provided. We cannot legally bill your insurance for services without your permission and cooperation. If you have coverage through a plan in which we participate, we are required to **collect your co-payment, if any, on the date of service**. We will bill your insurance for services only if you have supplied us with current, complete and verifiable information **before your exam**. If you have VSP insurance, we must rely on you to tell us so. **We cannot bill VSP retroactively**. Please **bring your current insurance card to every appointment**. Please also send us a copy of any new card you receive for new or continuing insurance. **You are financially responsible for charges not covered by your insurance, and payment must be made as soon as responsibility is determined –- often on the date of service.**

Contact Lens Services are not included in standard eye exams.
Contact lens services consist of contact lens fittings, consultations, prescriptions and lens replacements. We are happy to provide contact lens services, but fees for such are separate from other eye exam fees.

5. **Copayments and payments toward your deductible must be paid on the date of service.**

6. The balance remaining after the insurance portion is paid or denied is due within 30 days. If you disagree with the insurance determined benefit, you must contact your insurance directly.

7. If you do not have insurance or your coverage is not verifiable at the time of your visit, **we will require that you pay in full for care on the date of your appointment**. In this case, we will provide you with a receipt that you may submit to your insurance for reimbursement, but **we will not bill your insurance unless instructed to**.

8. Our staff will gladly discuss your estimated medical care costs; however, **the doctor determines actual fees at the time services are provided.**

9. We realize that temporary financial problems may affect timely payment of your account. If such problems occur, contact our billing specialist promptly to make arrangements. Do not wait until the bill is sent to collections.

PLEASE CONTINUE TO THE BACK PAGE ➔

DILATION

Dilating drops are used to enlarge the pupils of the eye, allowing the doctor a better view of the inside of your eye. Dilating drops frequently blur vision, especially reading vision, for a length of time which varies from person to person, typically 3-6 hours. Bright lights may also become bothersome; use of sunglasses is recommended after dilation. It is not possible to predict how much your vision will be affected ahead of time. Because driving may be difficult immediately after an examination, it is best to make arrangements not to drive yourself home. Dilating drops are part of a complete ophthalmologic examination; if you do not wish to be dilated, please tell the eye doctor at the beginning of the exam. We do not use dilation "reversal" drops because we find that they often cause headaches.

SPECIAL SERVICES

Missed Appointment Fee

We set aside physician time to see each patient. Too often, an appointment is not kept, or is cancelled with too little notice to schedule the time with another patient. Therefore, **our policy requires payment for appointments that are not kept, or are cancelled or rescheduled with less than 24 hours' notice** (only business days included). **The cancellation fee is $50.**

Courtesy Service Fees

With reduced medical reimbursements, we must ask that patients reimburse the practice for "courtesy services" such as letters and forms for employers, airlines, athletic clubs, and missed school. **This fee is $35**. Note that a receipt for payment is always available to you at no cost, and should suffice for evidence of an appointment, date and time. The fee for completion of DMV forms is **$35 and short DMV visual field is $80**.

A nominal fee must also be charged to cover our costs when we send a copy of your records to you, to another provider (unless we are referring you), or for disability or other legal claims. **This fee is $30**.

UNDERSTANDING AND AGREEMENT

This is my direct assignment of payment as defined in the rights and benefits of my insurance policy, where I assign and instruct direct payment to Denny Eye & Laser Center, or to anindividual physician member, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the totalcharges of the professional medical care provided to me. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a prompt manner, any balance of said professional charges over and above insurance payment, as due. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize release of any information required of my insurance to process a specific claim.

I acknowledged by my signature below, I authorize Denny Eye and Laser Center to bill my insurance for charges incurred for my exam(s) and procedure(s). I also understand the payment policies of Denny Eye and Laser Center and that I'm financially responsible for all charges incurred regardless of insurance coverage. If the amount due is not paid, I agree to bear any late fees, collection costs, court cost, and legal fees which may occur. I have read the financial policy and completed the "Patient Registration" and "Patient History" forms. I certify that this information is true and correct, to the best of my knowledge, and will notify you of any changes. I acknowledge that I have received a copy of this Notice of Financial Interest and Your Financial Responsibility document.

_____ _____

Patient signature Date

_____ _____

Parent (*if patient is a minor)* Date

Denny Eye & Laser Center
NOTICE OF PRIVACY PRACTICES

Dear Patient:

As ever, our practice is dedicated to providing the highest quality medical care, which includes treating all patients with respect for their privacy. This notice describes how medical information about you may be used and disclosed and how you can get access to your medical information, as required by the Privacy Regulations created by the passage of the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Please review this information carefully.

COLLECTION, USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

In the course of providing you with evaluation, treatment, and other services, this practice collects information about you and your health. This information is stored in paper and computer records, and constitutes your medical record. The medical record we create is the property of this practice, but the information it contains belongs to you. The law permits us to use or disclose your health information for the following purposes:

TREATMENT We use and disclose medical information about you to provide your medical care. We may disclose your name and diagnosis to employees of other locations where we may provide services, such as a hospital where Dr. Denny may perform surgery for you. We may share your medical information with other physicians or individuals who offer services that you seek and we do not provide, such as eye photography or pharmacy dispensing. We may also disclose information, under limited circumstances, to members of your family or others who can help you obtain treatment, make medical decisions, or maintain treatment regimens.

PAYMENT We use and disclose medical information about you to obtain payment for services provided to you. For example, we give your health insurer the information they require in order for them to pay us for services we provide you.

HEALTH CARE OPERATIONS We may use and disclose medical information about you to operate this medical practice, for example:

- reviewing and improving the quality of care we provide, evaluating and training of our staff
- obtaining authorizations or referrals through your insurer
- complying with medical reviews, certification, licensing or credentialing, legal services or audits
- submitting bills electronically
- leaving messages to remind you of your appointments

REQUIRED BY LAW We will disclose your health information when we are required to do so by law:

- to public health authorities or health oversight agencies authorized to collect such information
- when necessary to reduce a serious threat to health and safety
- to report suspected abuse, neglect, domestic violence or other suspected crimes
- as required by judicial or administrative proceedings
- as required by law enforcement officials, federal, military, or national security regulations
- to coroners or organizations involved in organ or tissue donation as necessary

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

For uses that are not required by law, or for treatment, payment, or health care operations, we will require your written authorization to release information. You may revoke your prior authorization in writing to our practice at any time.

PATIENT COPY

You can request that our practice communicate with you in a certain manner or location (for example, only call you at home, not at work).

You can make a written request for certain additional restrictions in our use or disclosure of your health information. We are not required to agree to your request, however, we will accommodate reasonable requests and will respect any agreements we make.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical and billing records. You must submit your signed, written request to:

Denny Eye & Laser Center
711 Van Ness Ave., Suite 300,
San Francisco, CA 94102
OR
Fax to (415) 567-2973
Please include any copying fees

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, submit your signed, written request to the same address as listed directly above. Please also indicate a reason that supports your request for amendment.

Denny Eye & Laser Center does not sell any patient information or share your email address with any third parties. We may use your mailing address or email address to send you news or information about the Denny Eye & Laser Center and Pacific Vision Foundation which supports our work at The Eye Institute. If you do not want Denny Eye & Laser Center and Pacific Vision Foundation to use your mailing address or email for the purpose of sending you news or information about the practice, please inform the front desk staff. Your request will be handled promptly but you may still receive marketing communications that were already in process prior to receipt of your request.

You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

You have the right to file a complaint if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. File to:

Denny Eye & Laser Center 711 Van Ness Ave., Suite 300 San Francisco, CA 94102 FAX (415) 567-2973	**Department of Health and Human Services Office of Civil Rights** 200 Independence Ave, S.W. Room 509F HHH Building Washington, DC 20201

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