Children's Eye Care of Los Gatos, Inc.

250 Almendra Avenue, Los Gatos, CA 95030
408-399-9009 Fax 408-399-9073

WELCOME TO OUR OFFICE

We would like to take this opportunity to welcome you to our office. It is our goal to provide patients with the best comprehensive eye care possible and to create a comfortable environment for children, parents, and adult patients. We have included the following information to help make your visit as comfortable as possible. Please ***read this information very carefully*** and call us with any questions. In order to facilitate your visit, we ask that you fill out all enclosed paperwork and bring it with you to your appointment.

All new patients are asked to arrive 15 minutes early to allow time to process your registration forms and insurance.

Rescheduled or cancelled appointments require a 24 hour prior notice to accommodate our other patients.
Cancellation Policy: If you are unable to keep your appointment for any reason, please give us a 24 hour prior notice. ***There will be a $50.00 cancellation/no show fee for each missed appointment***.

Please allow one and a half hours for new patient examinations.
Routinely, eye drops are used on the first visit for a complete medical eye examination and refraction. Refractions are done to determine the best possible vision correction. Furthermore, refraction helps us determine whether medical, optical, or surgical intervention may be necessary. This is a very important part of the complete eye examination, especially in children who may have amblyopia (lazy eye) or strabismus (crossed eyes). The drops will temporarily blur vision for 4 to 12 hours, but in some cases up to 32 hours. Plan to avoid near tasks immediately after the appointment. Please bring sunglasses if you have them.

In order to be fair to patients who are punctual, anyone arriving **15 minutes or later** to their appointment time will be rescheduled for the next available appointment.

Please park on the street where there is free 2 hour parking. The parking lot located in the back of the office building is **employee parking only**.

Finally, we would like to remind you that we try to give individual attention to you and/or your child.
It is best to limit children's visits to the child and parents. Siblings may distract you or the doctor from the importance of the visit.
A parent or legal guardian must accompany patients under the age of 18.

If anyone other than the parent or legal guardian will be bringing the patient in, a **signed note** giving permission to dilate the eyes must be provided to our office the day of or prior to the appointment.

We look forward to meeting you.

Children's Eye Care of Los Gatos, Inc.

Patient Information

Patient Name: _____
Last First M.I.

Address: _____

_____
City State Zip

Home Phone: _____

Mobile Phone: _____

Date of Birth: _____

Email Address: _____

**** For billing purposes please be sure to provide a physical address.**

No PO Box numbers will be accepted**

Pediatrician: _____

Address: _____

Telephone: _____

Referring Doctor: _____

Address: _____

Telephone: _____

Are siblings patients in our office? Y N

If so, what are their names? _____

Parent/Guardian Information

Mother: _____

Date of Birth: _____

Address (if different from above): _____

_____

Employer's Address/Telephone: _____

_____

Father: _____

Date of Birth: _____

Address (if different from above): _____

_____

Employer's Address/Telephone: _____

_____

Billing Information

Please complete for person responsible for bill

_____
Last Name First Name M.I. Relationship to Patient

Insurance Information

Please provide all pertinent insurance information. If you have coverage by more than one carrier, please supply information for both carriers. Please present your referral form and insurance cards to the receptionist.

_____
PRIMARY Insurance Policy No. Group No.

_____
Subscriber Name Relationship to Patient Subscriber's Date of Birth

_____
SECONDARY Insurance Policy No. Group No.
Subscriber Name Relationship to Patient Subscriber's Date of Birth

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I permit a copy of this release to be used in place of the original

_____ _____
Signature of insured or authorized person, patient/parent of minor Date

PATIENT BACKGROUND INFORMATION

PLEASE COMPLETE ALL QUESTIONS ON THIS FORM

Patient Name: _____ M/ F Date of Birth: _____/_____/_____

Reason for Referral:_____

_____

Birth Weight:_____ Full Term or Premature:_____If Premature, how many weeks early:_____

Were there any pregnancy complications? _____

_____

Normal Developmental Milestones ☐Yes ☐No Explain: _____

_____

Other Siblings:_____

Family History (Please list any conditions present in relatives, such as "lazy eye", crossed eyes, thick glasses, cataracts at birth, or autoimmune disease such as: lupus, diabetes, thyroid)_____

_____

Medical History (include all hospitalizations):_____

_____

Surgical History (include all surgical procedures performed):_____

_____

Current Medications:_____

_____

Allergies to **ANY** Medications:_____

_____

Other information the Doctor should know:_____

_____

REVIEW OF SYSTEMS

DOES YOUR CHILD COMPLAIN OF OR PRESENTLY HAVE SYMPTOMS OF ANY OF THE FOLLOWING?

Please Provide Specifics

- ☐ Headache: _____
- ☐ Neck Pain / Stiffness:_____
- ☐ Ear Pain / Infection/ Decreased Hearing: _____
- ☐ Difficulty Breathing / Wheezing: _____
- ☐ Joint Pain / Stiffness: _____
- ☐ Skin Rash or Other Markings:_____
- ☐ Delay in Motor Skills (Walking, etc…): _____
- ☐ Nausea / Vomiting/ Stomach Pain:_____
- ☐ Diarrhea:_____
- ☐ Fever / Chills: _____
- ☐ Flu-like Symptoms, Cough or Sore Throat:_____
- ☐ Urinary pain, Frequency, Cloudiness, Bloodiness:_____
- ☐ Early signs of Puberty / Abnormal Menstruation: _____
- ☐ Other: _____

_____

☐ **Please check if none of the above**

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ALL PATIENTS

- To be fair to all parties, please provide no less than a **24-hour notice in the event of cancellation**. Missed appointments that were not cancelled in advance will be subject to a **$50.00** fee.
- There will be a charged fee of $25* for each check returned by the bank.
- Co-payments are due at the time of service. There will be a $35* charge to send a bill for a co-payment.
- Unpaid balances over 30 days are subject to a rebilling charge of $35*. (* Bank fees and rebilling charges are subject to change at any time)
- Please bring your medical insurance card. If you have any benefit questions, contact your insurance company **prior to** your visit. If we are not contracted with your insurance, full payment will be collected at the time of service. A copy of the detailed charges will be available for you at the end of the visit so that you may submit a claim for out of network reimbursement.
- **If you have a medical deductible that has not been met, we will collect at your insurance's contracted rate at the time services are rendered. Should your insurance company cover any part of the visit, a refund will be sent to you directly. If you have questions about your deductible, please call your insurance company.**
- **Non-covered services, co-payment and a refraction fee (maximum $95) will be collected at the time of service.**
- Please check with your insurance to see if routine eye examinations are a benefit of your medical plan. Most health insurance companies will not pay for services rendered on a routine eye examination unless the examination reveals a medical problem.
- Nearsightedness, farsightedness and astigmatism are not considered medical diagnoses.
- Our office **does not** contract with VSP, EyeMed or any other vision plan. You may submit refraction fees to your vision plan for out of network reimbursement. Reimbursement varies by plan benefits.
- Being referred to us by your pediatrician does not necessarily mean you have a medical eye condition.
- Under most circumstances, your health insurance company will not pay for contact lens examinations and contact lenses.
- Your insurance company is billed by the diagnosis and procedure code provided by the doctor after the examination is completed and treatment has been rendered.

I consent to the necessary medical care and treatment. I have medical insurance coverage and assign payment directly to Children's Eye Care of Los Gatos of all surgical and/or medical benefits for services rendered. I authorize the doctor to release all information necessary to secure the payment of benefits. I am financially responsible for all charges whether or not paid by insurance.

Signature of patient/ parent/ legal guardian Date

MINOR PATIENTS

My signature confirms that I am the person legally responsible for the patient and I consent to the necessary medical care and treatment of the patient.

Signature of parent or legal guardian Date

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Refractions

Refraction is done to determine whether you are nearsighted, farsighted, have astigmatism and whether glasses are necessary or need to be changed. This is a very important part of a complete eye examination, especially in children who may have amblyopia (lazy eye), strabismus (crossed eyes), who are less than 5 years old, or have failed a vision screening examination. Most importantly, it will determine how well you can see. If your vision cannot be corrected with glasses, you may have some form of eye disease.

Although a refraction is extremely important, *many* medical insurance companies do not pay for this service. Some medical insurance plans cover refractions for children under age 18; however, you should contact your plan for specific information. **Our charge for a refraction is $85 for an established patient and $95 for a new patient**. If you have a vision insurance plan, such as Vision Service Plan (VSP), Medical Eye Services (MES), or EyeMed, most of this charge may be covered on an out of network basis. Remember, vision insurance is designated to cover routine eye examinations for refractive errors (myopia-nearsighted, hyperopia-farsighted, astigmatism, or presbyopia-reading glasses over the age of 40). Medical insurance will cover the portion of the eye exam that is not routine and may include medical eye conditions such as amblyopia, strabismus, cataracts, glaucoma, etc.

Childhood Eye disorders require a thorough medical evaluation. Additional diagnostic testing, such as refraction, is required. Refraction is the determination of the optical properties of the eyes. Refraction is needed to properly diagnose and effectively treat many causes of lazy eye (amblyopia), or misalignment of the eyes (strabismus). If undetected, these conditions may lead to permanent loss of vision. Refraction (92015) is a medical necessity and is not included as a work component of any CPT code and should be reimbursed separately.

I have read and understand that I am financially responsible if my insurance carrier denies payment for this service.

Signature of patient/ parent/ legal guardian Date

Office Policy Statement on Amblyopia Diagnosis

Amblyopia is a medical condition which requires medical treatment. Amblyopia (ICD codes 368.0, 368.00, 368.01, 368.02, 368.03) is typically a preventable and treatable form of vision loss. Unless amblyopia is treated promptly during childhood, structural changes occur in the brain of the amblyopic child, resulting in decreased visual function. Optical correction such as eyeglasses or contact lenses may be medically indicated as a part of amblyopia treatment in addition to other modalities, such as patching and/or pharmacologic treatment. Unless amblyopia is treated during childhood, vision loss is likely to be irreversible.

Because many insurance carriers have begun to deny benefits for Amblyopia, you may get a bill from our office. As always, we will continue to bill your insurance for these services. However, if you receive a statement from our billing department requesting payment, please contact your insurance carrier. They will assist you with any questions you may have regarding responsibility.

I have read and understand that I am financially responsible if my insurance carrier denies payment for this service.

Signature of patient/ parent/ legal guardian Date

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PERMISSION TO DISCUSS OR RELEASE CONFIDENTIAL INFORMATION

By completing this form, you will allow the staff of Children's Eye Care of Los Gatos, Inc. to communicate with family members, health care providers, or others as is deemed medically appropriate. If someone other than yourself is responsible for payment of your services, you will need to include their name on this list.

I, _____, grant permission to the staff of Children's Eye Care of Los Gatos, Inc. to discuss or release confidential information related to my care with the following individuals:

Name	**Relationship**

This authorization is considered valid until revoked in writing or until the following expiration date: _____

_____

Signature of patient/ parent/ legal guardian Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I,_____, have read a copy of Children's Eye Care of Los Gatos, Inc. Notice of Privacy Practices with an effective date of November 9th, 2011.

☐ Yes, I would like a copy of the Notice of Privacy Practice

☐ No, I would not like to receive a copy of the Notice of Privacy Practice

_____

Name of Patient

_____ _____

Signature of patient/ parent/ legal guardian Date

For a copy of our Notice of Privacy Practices please log on to our website at www.childrenseyecarelg.com