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 medical 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** than 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**.

We look forward to meeting you.

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Patient Information

Patient Name: _____
Last First M.I.

Address: _____

_____
City State Zip

Home Phone: _____

Mobile Phone: _____

Date of Birth: _____

Email Address: _____

Primary Care Doctor: _____

Address: _____

Telephone: _____

Referring Doctor: _____

Address: _____

Telephone: _____

EMERGENCY CONTACT INFORMATION

Please list who to contact in the event of an emergency

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

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 or parent of minor **Date**

PATIENT BACKGROUND INFORMATION

PLEASE COMPLETE ALL QUESTIONS ON THIS FORM

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

Reason for Referral: _____

_____

_____

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

DO YOU PRESENTLY HAVE SYMPTOMS OF ANY OF THE FOLLOWING?

Please Provide Specifics

- ☐ Headache/ Migraine: _____
- ☐ Neck Pain / Stiffness: _____
- ☐ Dizziness/ Hearing Loss: _____
- ☐ Difficulty Breathing / Wheezing: _____
- ☐ Joint Pain / Swelling: _____
- ☐ Skin Rash or Other Markings: _____
- ☐ Chest Pain: _____
- ☐ Nausea / Vomiting/ Stomach Pain/ Diarrhea: _____
- ☐ Fever / Chills/ Night Sweats: _____
- ☐ Flu-like Symptoms, Cough or Sore Throat: _____
- ☐ Urinary pain, Frequency, Urgency or Difficulty: _____
- ☐ 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 prior 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 anytime)
- Please bring your medical insurance card. If you have any benefit questions, contact your medical 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, Inc. for 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 Date

MEDICARE PATIENTS

I hereby certify that I am eligible for Medicare coverage. I request that payment of authorized Medicare benefits be made to Children's Eye Care of Los Gatos, Inc. on my behalf for any services furnished to me by Dr. Anita Breckenridge, MD or her employees. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I authorize release of information necessary to pay the claim. If other information is indicated in item 9 of electronically submitted claims; my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier.

Signature of patient 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.

It may be possible for us to perform an eye examination in order to be sure you have no serious eye disease without performing a refraction; however this will be up to the sole discretion of the physician at the time of service. Ideally, a complete eye examination *should* include a refraction, especially if you cannot see well.

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

Signature of patient 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 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