Beverly Hills Eye Associates

450 NORTH BEDFORD DRIVE, SUITE 101
BEVERLY HILLS, CA 90210

PHONE: (310) 274-9205
FAX: (310) 274-7229

Patient Information

Last Name: First: Middle:

Marital status (circle one):
Single / Married / Other

Cell Phone: Home Phone: Work Phone:

Birth date: / /

Age:

Sex (circle one):
Male / Female / Other

Social Security Number:

Driver's License Number:

Email Address:

Preferred Method of Contact:
❑ Phone ❑SMS
❑Mail ❑Email

Address:

Street City State Zip

Race:
❑American Indian ❑Alaskan Native ❑Asian ❑Black or African American ❑Native Islander or Other Pacific Islander
❑White ❑Declined to Specify ❑Other_____

Ethnicity:
❑Hispanic/Latino ❑Not Hispanic or Latino ❑Declined to Specify

Preferred Language:

Occupation:

Employer:

Employer Phone:

Emergency Contact:

Cell Number: Home Number: Work Number:

Relationship:

Primary Care Provider: Phone Number: Fax Number:

Referred to clinic by (please check one box):
❑Dr. _____ ❑ Family _____ ❑Website ❑Yelp
❑Friend _____ ❑ Other _____

Insurance Information

Person responsible for bill:

Birth date: / /

Address (if different):

Preferred Phone:

Primary Insurance: Secondary Insurance: Name of Card Holder:

Vision Insurance: Name of card holder:

Authorization to release: I hereby authorize Peter J. Cornell, M.D., Inc. to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.
Assignment of insurance benefits: I hereby assign to the doctor all money to which I am entitled to expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over the above my indebtedness will be refunded to when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

Patient's Signature Responsible Party's Signature Date

Medical History Questionnaire

Patient Name: _____ Date: _____

Do you presently have any problems in the following areas? Please mark YES or NO on <u>all</u> questions.

Eye History	Yes	No
Loss of vision, blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Loss of side vision		
Double vision		
Dryness		
Mucous discharge		
Redness, sandy, gritty feeling		
Itching, burning		
Foreign body sensation		
Excess tearing/watering		
Glare/light sensitivity		
Eye pain/soreness		
Infection of eye or lid		
Tired eyes		
Crossed eyes, lazy eye		
Drooping eyelid		

Social History	Yes	No
Do you have visual difficulty driving during the day?		
Do you have visual difficulty driving at night?		
Do you currently wear contact lenses?*		
Have you ever tried wearing contact lenses?*		
Do you currently wear glasses?*		
Do you smoke Cigarettes?		
Do you drink alcohol?		

*If you answered **YES** to wearing contact lenses or glasses, how long have you been wearing your most recent prescription? _____

List any surgeries (including eye surgeries) you have had:

_____

_____

General/Constitutional	Yes	No
Fever		
Weight loss		
Allergic/Immunologic		
Chronic cough		
Dry throat/mouth		
Cardiovascular		
Respiratory problems		
Chronic bronchitis		
Gastrointestinal		
Genitourinary		
Genitalia, Kidney, Bladder		
Muscle, Joint, Swelling		
Neurological		
Psychiatric		
Endocrine		
Hematological/Lymphatic		
Blood		
Lymph nodes		

Do you have any medical or health problems?

_____

_____

Please list any known drug allergies:

_____

_____

Are you allergic to latex, tape, or iodine? (If yes, please circle) List any other: _____

_____

Please list any medications and ocular medications (drops) currently being used:

_____

_____

Please list any family history of medical or ocular conditions: _____

_____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____

Have you ever taken any of the following medications? (if yes, please circle): **Flomax, Hytrin, Cardura, Uroxatral, Detrol, Rapaflo, and Tamsulosin**.

Reviewed By: _____

Date: _____

Notice of Privacy Practices

To Our Patients:

Please read the attached **"Notice of Privacy Practices"** (laminated page). Complete and return this page that will remain in your chart. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. If you would like a copy of the Notice of Privacy Practices, please ask our staff for a copy.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy practices from Peter J. Cornell, M.D., Inc.

Signature _____

Date _____

Name of Patient_____

Contact Number(s)

To respect your privacy, please tell us which of the following numbers we may call to communicate with you regarding Appointment Reminders, Lab Results, etc. List only the phone number, or numbers, you want us to call where we can leave messages if needed.

Home #_____ Work #_____

Cell # _____ Other #_____

Authorized Contact(s)

Please list those people with whom we may discuss your personal healthcare information (doctor, personal assistant, nurse, family members, friends, etc.)

1. Name of contact _____ Relationship _____

Phone # _____ Can we leave a message? ☐ Yes ☐ No

2. Name of contact _____ Relationship _____

Phone # _____ Can we leave a message? ☐ Yes ☐ No

3. Name of contact _____ Relationship _____

Phone # _____ Can we leave a message? ☐ Yes ☐ No

Beverly Hills Eye Associates
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Beverly Hills, CA 90210

Phone (310) 274 - 9205
Fax (310) 274 - 7229
Web www.bhlasik.com

Financial Agreement

Thank you for choosing our office as one of your health care providers. We are committed to giving our patients proper care and treatment.

As a courtesy, the office will bill your insurance for you. A **current copy of your insurance card is required at your date of service** for our office to bill your insurance directly. Payment in full is due at your appointment if you are not able to provide us with a copy of your current insurance. Should your insurance need more information or deny the claim, it is the patient's responsibility to comply with the insurance company to provide needed information and/or pay for the charge in full.

As the patient, any charges that are not covered by your insurance are your responsibility and you are financially responsible. It is the patient's responsibility to verify insurance coverage before the time of service. If we are not providers under your insurance or if your insurance refuses to pay based on health benefits provided, complete payment is your responsibility despite the insurance company's arbitrary calculation of UCR (Usual, Customary, and Reasonable) rates.

Our office is not contracted with Medi-Cal. Unfortunately, if Medi-Cal is your primary insurance coverage, we are unable to see you in our office. We cannot bill Medi-Cal for services rendered and we are unable to accept any form of payment from patients with Medi-Cal. If Medicare is your primary insurance and Medi-Cal is secondary, we can see you in our office. We will bill Medicare for services rendered. However, you are financially responsible for all non-covered charges as well as any coinsurance and deductible amounts that Medicare did not cover.

If you are a cash pay patient because you do not have insurance or we are not providers for your insurance, payment in full is due at the time of service.

Complete payment for known amounts, such as co-payments and non-covered charges, are due at your scheduled appointment. Coinsurance and deductible amounts vary with each insurance company and cannot be determined until after claim submission. Payment for these amounts are expected within **30 days** of receiving a billing statement. It is the patient's responsibility to update any demographic information necessary.

Our service fees are rendered as usual and customary for our geographic area. If you have any questions regarding your insurance information or financial standing with our office, please contact our billing department at (310) 274-9205 Tuesday-Friday (9:00am to 1:00pm) or by email at billing@bheyes.com.

Financial Agreement

I understand that I am financially responsible for any charges that my insurance does not cover or refuses to pay. My signature is an agreement to pay any balance in full by cash, check, or credit card. I am aware that overdue balances may be sent to an outside collection agency.

I understand that for my insurance to be billed by the office as a courtesy, I need to provide accurate and current demographic and insurance information at my scheduled appointment.

I understand that ultimately, I am financially responsible for any and all payments of services.

My signature is a contract that I have read, as well as understand and agree to the Financial Agreement.

Patient or Guardian Signature: _____ **Date of Birth**: _____

Patient Name (please print): _____ **Date**: _____

Non-Covered Vision Testing and Evaluation Notice

To our patients,

Most medical insurance companies, including Medicare, do not pay for the refraction. A refraction is the portion of the eye examination that measures for a glasses prescription.

If you are a member if a **PPO, Private,** or **Medicare** insurance that has a contract with our office, we will submit the medical portion of your examination to them. You are responsible for any co-pay amount plus the refraction charge of ninety dollars **$90.00*. In the event your glasses prescription needs to be altered or rechecked, the refraction fee will be valid for ninety (90) days only.**

If you have vision insurance, the refraction charge will be covered in full. Please read the attached copy of "**Do you have a Vision Plan?"** (laminated page). If you would like a copy of "Do you have a Vision Plan?" please ask our staff for a copy.

If you are a patient that requires **prisms in their glasses**, there will be an **additional charge of $45.00*.**

Initial _____

Contact Lens Fitting and Evaluation

Contact lenses are medical devices dispensed only by a prescription from a licensed eye care professional. Contact lens prescriptions expire after one (1) year. Your contact lenses must be fitted and evaluated on a yearly basis in order to renew your contact lens prescription.

The fee for this service is dependent upon the type of contact lenses you wear and the complexity of your contact lens fitting/evaluation. This fee **starts at $65.00*** and will be determined by your doctor at the time of your examination. This fitting and evaluation may be a **non-covered service** with your medical health insurance or vision plan, meaning that you may be responsible for the contact lens fitting and evaluation fee.

Any questions about this fitting and evaluation fee can be directed to your doctor during your examination.

Initial _____

*subject to change