**EYE CARE INSTITUTE**
A Medical Corporation

**Bruce P. Abramson, MS, OD**
*Optometry*
*Contact Lenses*

**Arwa Alsamarae, MD**
*Comprehensive Ophthalmology*
*Glaucoma Consultation*

**Venkatesh Brahma, MD**
*Comprehensive Ophthalmology*
*Neuro-ophthalmology*

**Nina Ni, MD**
*Comprehensive Ophthalmology*
*Cornea/External Disease*
*Laser Vision Correction*

**Daniel G. Rich, MD**
*Comprehensive Ophthalmology*
*Laser Vision Correction*

**Avni Shah, MD**
*Comprehensive Ophthalmology*
*Glaucoma Consultation*

**Lillian Yang, MD**
*Comprehensive Ophthalmology*

3035 Cleveland Ave. Suite 100
Santa Rosa, CA 95403
**P**: (707) 546-9800
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**www.see-eci.com**

***Preparing For Your Visit With***
***Eye Care Institute***

Your appointment with Doctor_____is on M / T / W / Th / F _____. Please report to the reception desk at _____ am/pm for your _____ am/pm appointment. This additional time is needed to prepare your medical record prior to your appointment and review the information you have provided us.

The enclosed **patient information form** will assist us in the processing of your insurance claim form(s). The **medical history form** will provide your physician with valuable information about your current medical condition(s). Completing these forms prior to your appointment will facilitate your time with us. Please answer briefly. **After completing these forms please bring them with you to your appointment.** ***You may also fax the forms to 707-528-4967. Doing so will expedite your check-in process.***

In order to process your insurance billing, ***we must make a copy of your insurance card(s)***. ***Please bring your insurance card(s) to your appointment or mail a copy in advance (front & back). Insurance co-payments are payable at the time of your visit.***

If you wear glasses, please bring them with you to your appointment. If you wear contact lenses, please bring your prescription. If you have an extensive list of medications please attach this list to your paperwork with dosage and frequency of each medication taken.

Patients under the age of 18 must be accompanied to their initial exam by a parent or guardian.

Thank you for your assistance. Please feel free to call if you have any questions 707-546-9800.

# *What to Expect From Your Eye Exam at Eye Care Institute*

***Your visit to our office may be a comprehensive eye evaluation that might take up to one and a half hours. Your visit may take longer if you need specialized testing or have complex eye problems. Please make sure to allow time for your appointment.***

Your evaluation will begin with a medical history that will include any previous ophthalmic history. Please bring your current glasses and any pertinent contact lens information if you wear contact lenses.

To determine your best vision at distance and near, your visual acuity will be tested using a standardized eye chart.

A refraction, which checks the need for a glasses prescription, will be performed to determine your best possible vision, and may be necessary regardless of whether you plan on getting glasses or contact lenses. There is a $45.00 charge for a refraction. For an existing contact lens wearer there is a $35.00 -$45.00 charge for a contact lens evaluation should you request a contact lens prescription. Contact lens “fitting” fees vary. These charges may not be covered by your health insurance plan and payment will be required at the time of service.

Your eye muscle coordination may be tested to see if the light is being appropriately transmitted to your brain.

A slit lamp microscope examination will be performed to look at health of the front of the eye, which includes your cornea.

Intraocular pressure will be checked to see if your eye pressures are at a normal level.

All new exams normally include a dilated eye exam of both eyes. This important part of the exam will allow the doctor to look at the inside and back of the eyes and check the health of your lens, retina and optic nerve. You may want to bring a driver with you as some people find it difficult to drive after being dilated. Sun glasses should be worn after dilation.

Other tests may also be performed on an as needed basis, depending on what the preceding parts of your examination have revealed. These include formal visual field testing, photography, high resolution scans of the back of the eye, pachymetry to check your corneal thickness and ophthalmic ultrasound.

After the examination(s), your doctor will discuss the results of the exam with you and answer any questions you may have.

Eye Care Institute has an optical shop at each of its locations to take care of your optical needs. We are in-network providers for VSP (Vision Service Plan) and MES (Medical Eye Services). If you have coverage with either of these two plans please come prepared with the primary members name, date of birth, last four digits of their social security number and employer. This will help us confirm eligibility and obtain authorization for any services provided. **Please add an additional one half hour to your stay at ECI when purchasing new eyewear following your exam.**

**EYE CARE INSTITUTE (ECI)**

**PATIENT DEMOGRAPHIC** ***(please print)***

☐ New Patient ☐ Return Patient ☐ Update | Account #:_____

Patient Name_____ E-mail_____

Home Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Preferred Method of Notification: ☐ Patient Portal ☐ Cell Phone ☐ Home Phone ☐ Mail ☐ Other_____

Date of Birth_____ Age_____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Social Security #_____ Drivers License #_____ Exp. Date_____

Patient's Employer_____ Occupation_____

Is Today's Visit Work Related? ☐ Yes ☐ No If Yes, Date of Injury_____

Emergency Contact_____ Relationship_____ Phone_____

## IF PATIENT IS A MINOR

Father's Name_____ Employer_____

Work Phone_____ Cell Phone_____ Social Security #_____

Mother's Name_____ Employer_____

Work Phone_____ Cell Phone_____ Social Security #_____

## INSURANCE INFORMATION

Primary Insurance_____

☐ HMO ☐ PPO Co-Pay_____ Deductible_____

Name of Plan: ☐ Meritage ☐ Sutter Other_____

Primary Care Physician_____

Subscriber's Name_____

ID #_____ Group #_____

Birthdate_____ Social Sec. #_____

Subscriber's Relationship to Patient_____

Subscriber's Employer_____

Secondary Insurance_____

☐ HMO ☐ PPO Co-Pay_____ Deductible_____

Name of Plan: ☐ Meritage ☐ Sutter Other_____

Primary Care Physician_____

Subscriber's Name_____

ID #_____ Group #_____

Birthdate_____ Social Sec. #_____

Subscriber's Relationship to Patient_____

Subscriber's Employer_____

**Do you have a 3rd insurance?** Insurance Co._____ Subscriber_____

**Do you have a vision plan?** Insurance Co._____ Subscriber_____ Social Security #_____

## PERSONAL DEMOGRAPHIC

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other_____ ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other_____ ☐ Decline to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Other_____

## HOW DID YOU HEAR ABOUT US?

☐ My Primary Physician ☐ Family/Friend ☐ ECI Website ☐ Internet ☐ Advertisement ☐ My Optometrist ☐ Social Media

☐ Other_____ Specifically, who or what was the source?_____

## AUTHORIZATION FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I HEREBY AUTHORIZE EXAMINATION AND TREATMENT OF THE PATIENT NAMED ABOVE. I HEREBY AUTHORIZE THE DIRECT PAYMENT TO ECI OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO, OR ON BEHALF OF, THE PATIENT FOR ANY MEDICAL REASON AND/OR SURGICAL EXPENSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES. I HEREBY AUTHORIZE ECI TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION ACQUIRED IN THE COURSE OF MY CARE TO ALLOW THEM TO PROCESS ANY CLAIMS FOR MEDICAL AND/OR SURGICAL SERVICES.

_____ _____ _____

Responsible Party Signature Date Responsible Party Name (Please Print)

## **HEALTH INTAKE FORM** (please fill in all areas)

Name:_____Date of Birth:_____Date:_____

| **Past Eye and Medical History** | | | | | |
|---|---|---|---|---|---|
| | **Y** | **N** | | **Y** | **N** |
| Glaucoma | □ | □ | Hypertension | □ | □ |
| Macular degeneration | □ | □ | Diabetes Mellitus | □ | □ |
| Cataracts | □ | □ | Heart disease | □ | □ |
| Corneal disorder | □ | □ | Lung disease | □ | □ |
| Strabismus (crossed eyes) | □ | □ | Cancer | □ | □ |
| Retinal detachment | □ | □ | Arthritis | □ | □ |
| Diabetic retinopathy | □ | □ | Stroke | □ | □ |
| Eye surgeries: *(please list)* | | | Any other medical condition: | | |
| | | | Any other surgeries: *(please list)* | | |

**Please list all current Medications (Name and Dosage) including herbals and vitamins OR provide a list:**

_____

_____

_____

_____

**Allergies:**

_____

| **Family History:** | | |
|---|---|---|
| **Do any of your relatives have the following conditions:** | **Yes** | **No** |
| Diabetes | □ | □ |
| Glaucoma | □ | □ |
| Strabismus | □ | □ |
| Amblyopia | □ | □ |
| Age related macular degeneration | □ | □ |
| Retinal detachment | □ | □ |
| Other: *(please list)* | | |

| **Social History:** | | | |
|---|---|---|---|
| Current or former occupation: | | | |
| Have you ever or do you currently smoke: | □ Never | □ Former | □ Current |

Name of primary care physician: _____

Pharmacy and address:_____

**Patient Signature:**_____ **Date:** _____

**Reviewed and changes made: Signature:**_____ **Date:** _____

# Eye Care Institute Financial Policy

The physicians and staff of Eye Care Institute (ECI) are committed to providing you with the best possible health care. The following is a statement of the ECI financial policy.

- **Patients must complete all information forms prior to seeing the physician. A copy of your insurance card(s) and your ID will be made for your chart**
- **By law, we must collect your insurance copayment at the time of service. Be prepared to pay your copay at each visit and to pay for any services that will be applied towards your deductible at the time of service**
- **For uninsured patients, payment is expected at the time of service, unless other financial arrangements have been made prior to your visit**

## Health Coverage and Insurance

As a courtesy, we must submit insurance claims for insured patients. To ensure accurate claims processing, please provide your complete health plan or insurance and I.D. card. Your health plan, insurance company or Medicare may not cover some or all of the services provided. I understand that it is my responsibility to ensure that ECI is a participating provider for my health insurance network. Out of network services may be assessed a higher deducible, co-pay or co-insurance. I will be financially responsible for any services or balances due that are not covered by my health insurance. ECI accepts no responsibility for any referrals or prescriptions not covered by my plan.

## Payment on Balances Due:

Timely payment of your balance is required. Your balance is due upon receipt of your statement. Self-pay accounts are due at the time of service unless other financial arrangements are made. If payment is not made at the time of service, and financial arrangements are not made, your account will be considered past due once you leave the office.

If payment is not received, your account will be reviewed for possible outside collection.

If your payment by check is returned, be advised your account will be assessed a $25.00 returned check fee. The balance due from returned checks are payable by cash, credit card, money order or cashier's check.

## Narrative Reports and Forms

Reports and forms completed by physicians are subject to a fee (verify with the office staff the fee charged for each report/form). Payment is expected at the time you drop your form off to be completed.

## Cancellations/Missed Appointments

If you are unable to keep your appointment, please give our office at least 24 hours' notice. Failure to do so may result in a missed appointment/procedure change (fee is determined on the length of the appointment time scheduled). Insurances do not cover this expense and you are responsible for payment of this fee. Frequent missed appointments and cancellations interrupt the process of your treatment and may results in discharge from our office.

## Patient Relations

The physicians and staff of ECI are committed to providing you with the best possible health care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees or your financial responsibility.

Good doctor/patient relations are based on understanding and open communication. Our staff will make every possible effort to clarify any questions or concerns you may have regarding your account balance. If you have any questions concerning your bill, contact our billing service, the Practice Management Resource Group, at 877-443-4995 immediately.

**Coordination of Benefits:** Vision care plans (such as VSP or MES) only cover routine vision exams along with eyeglasses and contact lenses. Vision care plans can only be used once during a coverage period (usually a year). Medical insurance should be used if you have any eye health problem or systemic health problem that has ocular complications (ie: diabetes, glaucoma or cataracts). Your doctor will determine if these conditions apply to you. Vision care plans do not cover diagnostic testing. If you have an eye condition, ECI will bill the examination to your health insurance and the refraction to the vision care plan. If allowed by your plan we will use "coordination of benefits" to do this properly and to minimize your out of pocket expenses. You will be responsible for any remaining balances due for deductibles, co-pays, co-insurance or non-covered services.

X_____ _____

Signature of Patient or Responsible Party Date

Patient's Name (Please Print): _____

☐ 3035 Cleveland Ave. Suite 100 Santa Rosa, CA 95403 | **P**: (707) 546-9800 | **F**: (707) 528-4967

# Acknowledgement of Receipt of Notice of Privacy Practices

# Eye Care Institute

3035 Cleveland Ave. Suite 100
Santa Rosa, CA 95403

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the office, and that I will be offered a copy of any amended Notice of Privacy Practices.

| | |
|---|---|
| Signature | Date |
| Print Name | Telephone Number |

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.