What to Expect From your Eye Exam at Eye Care Institute

Please report to the reception desk 15 minutes prior to your scheduled appointment time. 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 Demographic Form*** will assist us in the processing of your insurance claim form(s). The ***Health Intake 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 mail the forms to the office or fax the forms to 707-546-4112 prior to your appointment. 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.

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 $50.00 charge for a refraction. For an existing contact lens wearer there is a $40.00 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 the 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. Sunglasses 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 to take care of your optical needs. We are in-network providers for VSP (Vision Service Plan). If you have coverage with this plan please come prepared with the primary member's 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.**

NOTICE OF PRIVACY PRACTICES

EYE CARE INSTITUTE

3035 Cleveland Avenue, Suite 100, Santa Rosa, California 95403
(707) 546-9800 • (707) 899-7980 Fax

www.see-eci.com

Effective Date: March 17, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may use your prescription medication history from other healthcare providers or pharmacies for treatment purposes. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign-in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in., We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 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

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.

Medical Debt:

A holder of this medical debt contract is prohibited by Section 185.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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 result 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.

Refraction Fee

A refraction, which checks the need for an eyeglasses 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 $50.00 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.

Coordination of Benefits:

Vision care plans (such as VSP) 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.

ACKNOWLEDGEMENT OF FORMS RECEIPT

EYE CARE INSTITUTE
A Medical Corporation

Printed Name: _____
Account #: _____
Date: _____
Relationship to patient: ___Self
___Parent or guardian of minor patient
___Guardian or conservator of an incompetent patient
___Beneficiary or personal representative of deceased patient:

CONSENT TO RECEIVE TEXTS AND/OR EMAIL COMMUNICATIONS:

Your follow-up care is important to us. We utilize text and e-mail to communicate upcoming appointment information and with our patients. By providing your e-mail and mobile telephone information below, you are consenting to receive text and/or e-mail alerts. By providing us with this consent and information, you will also receive the ability to pay your balance by phone. Please check one:

_Yes - I wish to opt in to text/e-mail alerts

_No - I will not share my electronic communication information. I do not wish to be contacted by text or e-mail. I understand that this choice may result in my not receiving certain communications regarding my appointments.

Signature: _____

ECI PRIVACY PRACTICES

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: _____

ECI FINANCIAL POLICY

I hereby acknowledge that I received a copy of this medical practice's Finance Policy. 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 deductible, 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.

Signature: _____

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:** _____