Registration Form

711 VAN NESS AVE. SUITE 300 SAN FRANCISCO, CA 94102
Phone/Text: (415) 567-8200 Fax: (415) 567-2973 contact@dennyeyelaser.com

DENNY EYE & LASER CENTER

NAME: _____ DOB: _____ **SEX:** ☐ Male ☐ Female
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS: _____
NO. & STREET CITY STATE ZIP CODE

PREFERRED LANGUAGE _____ SOCIAL SECURITY # (FOR INSURANCE VERIFICATION)_____

Please check mark your preferred contact info

☐ Home: (___) _____ - _____ ☐ Cell: (___) _____ - _____ ☐ Work: (___) _____ - _____ Email: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____
NAME NUMBER RELATIONSHIP

WHOM MAY WE THANK FOR REFERRING YOU? _____

Insurance Information

Primary Insurance

☐ NONE ☐ MEDICARE

Insurance company: _____ ID#: _____

Subscriber's Name: _____ Last 4 SSN: _____ Relationship: _____ DOB: _____

Secondary Insurance

☐ NONE

Insurance company: _____ ID#: _____

Subscriber's Name: _____ Last 4 SSN: _____ Relationship: _____ DOB: _____

Vision Insurance

☐ NONE ☐ VSP ☐ EYEMED ☐ MES VISION

Insurance company: _____ ID#: _____

Subscriber's Name: _____ Last 4 SSN: _____ Relationship: _____ DOB: _____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 1-800-633.3233 www.mbc.ca.gov INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY STATEMENT

By signing below, I give lifetime authorization for Medicare and/or Insurers to pay Denny Eye & Laser Center on my behalf for services provided to me by Kevin Denny, M.D. or any other person acting as an employee or agent of Dr. Denny. I understand that, regardless of my insurance status, I am ultimately responsible for fees for professional services provided as well as for products furnished through the Denny Eye & Laser Center, particularly for commonly non-covered services such as refraction. I am responsible for deductibles and copayments. Payment of copays is due on the date of service. Failure to pay copayments and balances at that time will result in an additional billing charge of $10.00. I agree to pay fees for late-cancelled or missed appointments. I also understand that, should I default on my account, all costs of attorney's fees, interest and/or cost of collections will be my responsibility. I authorize Denny Eye & Laser Center to release all information necessary to secure payments of benefits. I further agree thata photocopy of this agreement shall be valid as the original. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status of the above information.

➔Signature _____ Name _____
Signature of the Person Submitting this Form *Name of the Person Submitting this Form (print)*

Date: _____

OFFICE INITIALS: _____

DRY EYE QUESTIONNAIRE (DEQ-5)

1. Questions about **EYE DISCOMFORT:**

   a. During a typical day in the past month, **how often** did your eyes feel discomfort?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

   b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

2. Questions about **EYE DRYNESS:**

   a. During a typical day in the past month, **how often** did your eyes feel dry?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

   b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

3. Question about **WATERY EYES:**

   During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Score: 1a + 1b + 2a + 2b + 3 = Total

1a	+	1b	+	2a	+	2b	+	3	=	TOTAL

Proposed Screening criteria for the DEQ5 is >6 for Dry Eye

Notice of Financial Interests & Financial Responsibility

Denny Eye and Laser Center is committed to providing you the best medical care. We also want you to receive your maximum allowable insurance benefits. To meet both goals, we need your partnership and clear understanding of the following:

LATE ARRIVALS / MISSED APPOINTMENTS

- **48 HOUR CANCELLATION NOTICE.** We set aside physician time to see each patient. We ask that you notify or office within 48 hours if you need to cancel or reschedule, if not, it will be subject to a **$75 fee.**
- If you are more than 15 minutes late to your appointment time, we will try our best to fit your visit into the clinic schedule; however, there may be extra waiting time as we will try our best to accommodate any tardiness. We cannot guarantee that we will have sufficient time to complete your examination if you are late, we would be glad to reschedule your visit if you prefer.

INSURANCE

- **REFRACTION** is one of the most important parts of your eye exam. This is how we determine whether or not your vision can be improved with glasses. Medicare and most medical insurance plans consider refraction a "vision" service and not a "medical" service. **Our fee for refraction is $100**, at it is our office policy to collect this fee on the date of service in addition to any copayments your plan may require. Please let our office know if you have a vision coverage plan, if so, the refraction fee is included in your vision plan.
- Your insurance coverage of benefits and network eligibility is a contract between you and your insurer. We are not a party to that contract. Not all services are covered by all insurance plans. Covered benefits is not to be confused with the doctor's determination of which services are medically necessary or appropriate, so the doctor may need to perform non-covered services in order to care for you.
- It is your patient responsibility to call and verify network eligibility well in advance of your appointment. This can be done by calling your insurance and provide them Denny Eye and Laser Center's TAX ID: 94-3017042. Specifically ask if you have "routine eye examination" and "refraction/vision optometry" services as part of your covered benefits and if any exclusions apply. It is your best interest to know and understand your benefits, copays and deductibles before seeking services.
- Refraction is not a covered service under Medicare and most commercial insurances, this fee is $100. Please notify our office if you have vision insurance (VSP, EyeMed, MES). Refraction is one of the most important parts of your eye examination – this is how we determine whether or not your vision can be improved with eyeglasses. Although it can be essential information, most medical insurance plans consider refractions as a "vision" service and not a medical.

COPAYMENTS

- Our doctors have a medical care relationship with you, separate from any contractual agreements with insurance companies. Because you are the recipient of services, all charges are your responsibility as of the date the service was provided. If you have insurance coverage, we are required to collect your co-payment on the date of service. *If you would like to us to bill you for this co-payment, there will be an administrative charge of $10*. We will bill your insurance for services only if you have supplied us with current, complete and verifiable information prior to your exam. It is important to bring your current insurance card to every appointment and you must notify our office if there are any changes or if you have been issued a new insurance card.

FORMS / COURTESY SERVICE FEES

$35 – Letters and forms for employers, airlines, athletic clubs and missed school.
$35 – DMV form completion
$80 – DMV form completion with visual field testing
$30 – Copies of records to you or another provider (unless we are referring you), or for disability or other legal claims.

OFFICE INITIALS: _____

CONTACT LENSES

If you wear contact lenses, some or all of these services may not be covered by your insurance company. Contact lens services consist of the contact lens fittings, consultations, prescriptions and lens replacements. Details for fees and services are available on our Contact Lens Services sheet which is available at the front desk.

RENEWAL	
Spherical soft contacts	$95
Astigmatism (toric)	$125
Rigid Gas Permeable	$150
Monovision/BiFocal./Multifocal	$150
Keratoconus	$350 - $600

NEW FIT OR CHANGE	
Spherical soft contacts	$125
Astigmatism (toric)	$150
Rigid Gas Permeable	$200
Monovision/BiFocal./Multifocal	$300
Keratoconus	$350 - $600

Additional Services	
Training (Insertion & Removal) includes 3 sessions **not covered by insurance, requires additional 30 minutes after examination	$80
Additional training after 3 sessions	$30
Follow-up visits after 90 days	$60

By signing below, you agree that you have read and understand the above information to comply

➔Signature _____

UNDERSTANDING AND AGREEMENT

This is my direct assignment of payment as defined in the rights and benefits of my insurance policy, where I assign and instruct direct payment to Denny Eye & Laser Center, or to an individual physician member, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges of the professional medical care provided to me. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a prompt manner, any balance of said professional charges over and above insurance payment, as due. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize release of any information required of my insurance to process a specific claim. I acknowledge by my signature below, I authorize Denny Eye and Laser Center to bill my insurance for charges incurred for my exam(s) and procedure(s). I also understand the payment policies of Denny Eye and Laser Center and that I'm financially responsible for all charges incurred regardless of insurance coverage. If the amount due is not paid, I agree to bear any late fees, collection costs, court cost, and legal fees which may occur. I have read the financial policy and completed the "Patient Registration" and "Patient History" forms. I certify that this information is true and correct, to the best of my knowledge, and will notify you of any changes. I acknowledge that I have received a copy of this Notice of Financial Interest and Your Financial Responsibility document.

➔Signature _____ Name _____

Signature of the Person Submitting this Form *Name of the Person Submitting this Form (print)*

Date: _____

A copy of this document can be made available to you upon request

OFFICE INITIALS: _____

Medical History

711 VAN NESS AVE. SUITE 300 SAN FRANCISCO, CA 94102
Phone/Text: (415) 567-8200 Fax: (415) 567-2973 contact@dennyeyelaser.com

DENNY EYE & LASER CENTER

Patient Name: _____ DOB: _____

Primary Care Physician: _____

What brings you in today? _____

GENERAL HEALTH *Please mark all areas of concern regarding your health*

☐ Diabetes	☐ Arthritis	☐ Asthma	☐ Hypertension	☐ High cholesterol	☐ HIV / AIDS
☐ Stroke When?_____	☐ Thyroid / Graves disease	☐ Weight loss/fevers	☐ Heart attack When? _____	☐ Cancer type_____ year _____	
☐ NONE	☐ Other: _____				

EYE HISTORY *Please mark all that apply*

☐ Cataract	☐ Glaucoma	☐ Eye trauma	☐ Strabismus	☐ Amblyopia (lazy eye)
☐ Macular degeneration		☐ Retinal detachment	☐ Dry eye	
☐ NONE		☐ Eye surgery	☐ Other: _____	

FAMILY EYE HISTORY *Please mark all that apply*

☐ Cataract Who? _____	☐ Glaucoma Who?_____	☐ Eye trauma	☐ Strabismus	☐ Retinal detachment
☐ Macular degeneration Who? _____		☐ Eye surgery When? _____	☐ Dry eye	
☐ NONE		☐ Other: _____		

What percent of the time do you wear?	Glasses	☐ Never	☐ 100%	☐ 50%	☐ _____%
	Contact lenses	☐ Never	☐ 100%	☐ 50%	☐ _____%

MEDICATION LIST

Please specify your preferred pharmacy

Name:_____ Address:_____ Phone Number:_____

☐ Separate list provided

Date	Name of medication	Dose / Amount	Reason for use	Date stopped (M/Y)
ALLERGIES	☐ NONE	☐ Penicillin	☐ Codeine	☐ Sulfa

➔Signature _____ Name _____

Signature of the Person Submitting this Form *Name of the Person Submitting this Form (print)*

Date: _____

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Notice of Privacy Practices

DENNY EYE & LASER CENTER

As ever, our practice is dedicated to providing the highest quality medical care, which includes treating all patients with respect for their privacy. This notice describes how medical information about you may be used and disclosed and how you can get access to your medical information, as required by the Privacy Regulations created by the passage of the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Please review this information carefully.

COLLECTION, USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

In the course of providing you with evaluation, treatment, and other services, this practice collects information about you and your health. This information is stored in paper and computer records, and constitutes your medical record. The medical record we create is the property of this practice, but the information it contains belongs to you. The law permits us to use or disclose your health information for the following purposes:

TREATMENT We use and disclose medical information about you to provide your medical care. We may disclose your name and diagnosis to employees of other locations where we may provide services, such as a hospital where Dr. Denny may perform surgery for you. We may share your medical information with other physicians or individuals who offer services that you seek and we do not provide, such as eye photography or pharmacy dispensing. We may also disclose information, under limited circumstances, to members of your family or others who can help you obtain treatment, make medical decisions, or maintain treatment regimens.

PAYMENT We use and disclose medical information about you to obtain payment for services provided to you. For example, we give your health insurer the information they require in order for them to pay us for services we provide you.

HEALTH CARE OPERATIONS We may use and disclose medical information about you to operate this medical practice, for example:

- reviewing and improving the quality of care we provide, evaluating and training of our staff
- obtaining authorizations or referrals through your insurer
- complying with medical reviews, certification, licensing or credentialing, legal services or audits
- submitting bills electronically
- leaving messages to remind you of your appointments

REQUIRED BY LAW We will disclose your health information when we are required to do so by law:

- to public health authorities or health oversight agencies authorized to collect such information
- when necessary to reduce a serious threat to health and safety
- to report suspected abuse, neglect, domestic violence or other suspected crimes
- as required by judicial or administrative proceedings
- as required by law enforcement officials, federal, military, or national security regulations
- to coroners or organizations involved in organ or tissue donation as necessary

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

For uses that are not required by law, or for treatment, payment, or health care operations, we will require your written authorization to release information. You may revoke your prior authorization in writing to our practice at any time.

You can request that our practice communicate with you in a certain manner or location (for example, only call you at home, not at work).

PATIENT COPY

You can make a written request for certain additional restrictions in our use or disclosure of your health information. We are not required to agree to your request, however, we will accommodate reasonable requests and will respect any agreements we make.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical and billing records. You must submit your signed, written request to:

Denny Eye & Laser Center
711 Van Ness Ave., Suite 300
San Francisco, CA 94102
OR
Fax to (415) 567-2973
Please include any copying fees

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, submit your signed, written request to the same address as listed directly above. Please also indicate a reason that supports your request for amendment.

Denny Eye & Laser Center does not sell any patient information or share your email address with any third parties. We may use your mailing address or email address to send you news or information about the Denny Eye & Laser Center and Pacific Vision Foundation which supports our work at The Eye Institute. If you do not want Denny Eye & Laser Center and Pacific Vision Foundation to use your mailing address or email for the purpose of sending you news or information about the practice, please inform the front desk staff. Your request will be handled promptly but you may still receive marketing communications that were already in process prior to receipt of your request.

You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

You have the right to file a complaint if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. File to:

Denny Eye & Laser Center	**Department of Health and Human Services Office of Civil Rights**
711 Van Ness Ave., Suite 300	200 Independence Ave, S.W.
San Francisco, CA 94102	Room 509F HHH Building
FAX (415) 567-2973	Washington, DC 20201

PATIENT COPY