Welcome to Beverly Hills Optometry

Today's Date: _____ Date of Birth:_____ Sex: M/F

Patient Name: Mr. Mrs. Ms. Miss. Dr._____

Parent/Guardian Name (if patient is a minor)_____

Address:_____ City:_____ State:_____Zip Code:_____

Phone: Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email:_____ Occupation:_____ Hobbies_____

Emergency Contact: Name:_____ Relationship:_____ Phone:_____

How did you hear about us? _____

You are interested in: ____Comprehensive Eye Exam ____Contact Lens Evaluation ____ Other Eye Condition
____Advanced Eye Exam ____ Order Contact Lenses ____ Laser Vision Correction

Insurance Information

(Please present any vision/medical cards at check in)

Vision: (Please Circle) Eyemed Superior VSP Avesis Spectera Cigna Other_____

Name (of primary insured): _____ Date of Birth:_____ Last 4 of SS#_____

Medical PPO: (Please Circle) BlueCross BlueShield Aetna Medicare Cigna United Other_____

Name (of primary insured): _____ Date of Birth:_____ Last 4 of SS#_____

Medical Information

Do you wear: Glasses -> Distance/Computer/Reading/Bifocal/Progressive

Contacts -> Daily wear/Extended wear/ Astigmatism/Multifocal/Monovision/soft/rigid gas perm

Satisfaction with current glasses/contacts: Low 1 2 3 4 5 6 7 8 9 10 High

Do you use any eye care medications (prescriptions and/or over-the-counter): Y/N

if yes, please list:_____

List any injuries or surgeries to your eyes:_____

List any medications, supplements, and/or over-the-counter medications you are currently using:

_____

Do you have any allergies to medications: Y/N if yes, please list:_____

Do you have any seasonal/food allergies: Y/N if yes, please list:_____

Do you: _____smoke? _____drink alcohol? _____abuse substances? How often? _____

Please check any of the following that apply and circle for you (S) or family member (F):

__Blur at distance
__Blur at near
__Blur after reading
__Double vision
__Headaches
__Pregnant__mo
__Eye Fatigue
__Eye Strain
__Eyes itch
__Eyes water
__Light flashes
__Other
__Problems with glare
__Sensitive to light
__Seeing spots
__Asthma (S/F)
__Dry Eyes (S/F)
__Cholesterol (S/F)
__High Blood Pressure (S/F)
__Diabetes (S/F)
__Thyroid (S/F)
__Lazy Eyes (S/F)
__Cancer_____(S/F)
__Glaucoma (S/F)
__Cataracts (S/F)
__Color blindness (S/F)
__HIV+/AIDS (S/F)
__Macular Degeneration (S/F)

Family History of Eye Disease: Y/N If yes, explain _____
Family History of Diabetes: Y/N If yes, explain_ _____

Insurance Assignment and Release

I acknowledge that all insurances must be verified **PRIOR** to my appointment. Any insurances verified after the appointment will require the patient to submit a receipt directly to their insurance and the visit will be out of pocket, due at the time of the appointment. I certify that I have insurance coverage with the company(ies) I provided and assign directly to our providers and Beverly Hills Optometry, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of signature on all insurance submissions.

Vision Plan (Routine) Insurance

I acknowledge that Vision Plan (Routine) Insurance covers routine eye examinations, refractions, and may cover materials (contact lenses, glasses, ect) as specified by my plan benefits. I understand that Medical Examinations and Treatments are NOT covered under my Vision Insurance. I understand that Services related to medical conditions will be billed to my Medical Insurance or, if no applicable medical coverage exists, these services are my responsibility at the time of service.

Medical/Medicare/Supplement Authorization

Beverly Hills Optometry reserves the right to bill a patient's MEDICAL insurance based on the complexity of the visit and/or any medical/ocular findings, diagnosis, and/or other related conditions. I request that payment of authorized medical benefits and supplement benefits, be made to Beverly Hills Optometry for any services furnished to me.

Refraction

Refraction (testing for best corrected Visual Acuity) is not covered by medical insurance. In the absence of qualifying vision Insurance coverage, Refraction fees are the responsibility of the patient. Best Correct Visual Acuity Refraction-**$50.**
(If a patient requests a re-check, more than 30 days from date of service, there will be a **$50** charge).

Dilation

Please note that your eyes may be dilated during your examination. Dilation of your pupils may blur your vision and make you sensitive to light for several hours after your examination. While dilated, it is important to wear sunglasses outdoors and refrain from driving. For patients who are unable to dilate, we strongly advise OPTOS imaging (does not require dilation).

Pharmacy Prescriptions

You may be given a prescription for medications in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking.

HIPAA Privacy Practices

Beverly Hills Optometry follows HIPAA guidelines in regard to your PHI (Protected Health Information). I understand that I have certain rights to privacy regarding my protected health information. Copies of our HIPAA Policy are available at the Front Desk.

Co-pays, Deductibles and Non Covered Services

I acknowledge that I am financially responsible for co-pays, deductibles and non covered services; and that those amounts will be collected at the time of service.

Full Release of Medical Record

A patient may request a full copy of their medical record at any time. Please allow approximately 10-14 working business days to process your request. There will be a charge of $25 per request.

Cancellation/Reschedule

A specific time is reserved for a scheduled appointment. If you cannot keep your scheduled appointment, you must call more than 24 hours in advance. This gives the office adequate time to offer your scheduled time to another patient. If you cancel/reschedule an office visit with less than 24 hours' notice, the cancellation fee of **$75**. If the appointment is for a dry eye consultation and/or treatment, the cancellation fee is $150 or forfeit of a treatment session per contract.

Billing and Collections

I acknowledge that Beverly Hills Optometry is providing services in good faith and they will be appropriately compensated in a timely manner. It is the patient's and/or guarantor's responsibility to provide Beverly Hills Optometry with updated billing and insurance information on each visit. Beverly Hills Optometry has a "All Sales Final/No Returns" policy. Orders that have been cancelled will be available for exchange or in office credit only. There will be an Administration Fee of 25% applied to services not rendered, disputes, debt collections, etc..

Patient Signature_____ Date _____

Upgrade to a more advanced Comprehensive Exam

Retinal Digital Photography, Optical Coherence Tomography and Dry Eye Imaging may or may not be covered by insurance. In the absence of qualifying vision or medical insurance coverage, fees are the responsibility of the patient.

All tests help provide the highest quality of care. Please initial which elective imaging tests you want to receive.

Retinal Digital Photography-$60 _____

The Retinal Photograph is useful for early detection, monitoring, and/or treatment of eye and body conditions like **macular degeneration, diabetes, glaucoma, high blood pressure, high cholesterol, some cancers** and many more. It serves as a tool for preventative medicine and digitally documents the health of the retina for annual comparisons. **Strongly recommended for first time patients OR patients with a personal/family history of any of the above mentioned.**

Optical Coherence Tomography (OCT)-$60_____

Optical coherence tomography (OCT) is a non-invasive imaging test, similar to an MRI for the eye, to scan for eye diseases. OCT uses light waves to take cross-section pictures of your cornea and retina. This allows our doctors to map and measure their thickness. These measurements help to diagnosis diseases of the retina. These retinal diseases include age-related macular degeneration (AMD), glaucoma and diabetic eye disease. Dr. Silani and Dr. Younany review and document the slightest change from year to year. **This is necessary for patients considering Lasik.**

Dry Eye/Blepharitis/Stye/Allergy Imaging-$60_____

The OCULUS Keratograph® 5M is an advanced corneal topographer with a built-in keratometer and infrared color, camera optimized for external imaging of the eye and eyelid. Unique features include examining the meibomian glands, measuring the tear quality, evaluating the tear meniscus height and tracking the vessels of the conjunctiva. **Recommended for patients with eye irritations, watery eyes, blurry vision, dryness, redness, styes, blepharitis, contact lens patients, etc.**

Advanced Comprehensive Exam Package (all three)- $150_____

None of these tests require dilation

Patient Signature_____ Date _____

Parent Signature _____ Date _____