Central Coast Eye

Steven C. Johnson, M.D.
Specialist in the Treatment of Diseases of the Vitreous, Retina and Macula. Board Certified Fellow in the American Academy of Ophthalmology

Welcome!

We look forward to meeting you! We will do our best to make you comfortable and to provide the very best service. We believe you will find our doctor to be an exceptional premium cataract, and retinal surgeon. You will also find our staff professional, helpful and friendly.

Your new patient forms should be completed at home. Bring the completed forms, and your insurance cards with you to your appointment.

If you are unable to keep your appointment, please call us at **805-544-0102**. You will receive a reminder call the day before your appointment. If you do not receive a reminder call, please call our office. **We cannot guarantee you an appointment without a confirmation.**

Your Examination requires dilation of the pupils, which blurs your vision and will last several hours. It is best to have someone accompany you on your visit that is able to drive. We will provide dark sunglasses after your appointment to reduce glare from sunlight, and you may wish to bring your own sunglasses as well.

Depending on the nature of your condition, your examination and diagnostic testing may take anywhere from 30 minutes to 2 hours.

Please let us know if you have any questions or concerns. Thank you for choosing Central Coast Eye for your eye care services.

628 Californina Blvd. Suite C
San Luis Obispo, CA
ph:805-544-0102 fx:805-547-2095

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Name: _____

Address: _____

City: _____ State:_____ Zip: _____ Work Phone: (__ __ __) __ __ __ - __ __ __ __

Employer: _____ Home Phone: (__ __ __) __ __ __ - __ __ __ __

Social Security Number: _____ Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Date of Birth: _____ E-mail: _____

□ Male □ Female

Primary doctor: _____ Optometrist: _____

In Case of Emergency Notify: _____

Emergency Phone: (__ __ __) __ __ __ - __ __ __ __

Insurance

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

Relation to Patient: _____ Relation to Patient: _____

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with the carrier (s) stated above and assign directly to Central Coast Eye Inc. 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 paid by insurance. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient: _____ Date: _____

Responsible Party Signature: _____

Relation to Patient: _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other member of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permissions for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may sue and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety to the public or another person.
Military and Special Government Function: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future sues and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Bill Gloye

bill@centralcoasteye.com
Central Coast Eye, Inc.
628 California Blvd, Suite C
San Luis Obispo, CA 93401
805-544-0102

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me

Signed:
_____

Date:
_____

If not signed, reason why acknowledge was not obtained:

_____

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Central Coast Eye. We are committed to the treatment, preservation and advancement of your Retina care. Please understand that payment of your bill is considered part of your Retina care. The following is a statement of our Policy which we require that you read and sign before being seen by one of our physicians.

Your Responsibility

You are financially responsible for the services we provide to you. We understand that many patients arrange for health insurance plans to pay for a large portion of their medical expenses. However, the patient or legal guardian is responsible to pay our fees for all examinations and treatments in the office or in surgery, in the event that your insurance carrier deems our services non-covered or not payable. As a courtesy to you, we will file a claim to your insurance plan (s). However, we do expect payment of co-payments, co-insurance, deductible, non-covered services / drugs etc, at the time services are rendered. Payments will be collected either before or after the appointment. If you are unsure of your financial responsibility, please contact your insurance plan in advance to obtain this information.

Please remember your insurance benefits are a contract between you and your insurance carrier. Our insurance billing specialist is available to help with any assistance you may require, and to help with an estimate of your financial responsibility.

Non-Covered Services Condition

Central Coast Eye is dedicated to the preservation and treatment of your retinal condition. Since we are a specialty practice, some procedures that may be performed in your treatment plan could be deemed non-covered by your insurance plan. As a courtesy to you, we will file the services to your insurance carrier for consideration of reimbursement. In the event that these services are determined to be a non-covered service by your benefit plan, it is your responsibility to pay for the services rendered. Our billing specialist is available to you to review these out of pocket expenses with you prior to services being rendered.

Prior Balance

Patients with a balance from prior services rendered will be required to pay that balance in full before being seen by our physicians. If the prior balance cannot be paid in full, you will be asked to speak to our billing specialist to make payment arrangement determinations based on our payment policy before being seen by the physician.

Patient without Insurance Coverage (Self Pay)

Central Coast Eye is pleased to be able to provide services to patients that do not have insurance coverage. However, if you do not have insurance you will be expected to pay:

1: Minimum deposit of 1/2 of the charges due the same day services are rendered.

2: The balance will be due in full no more than 30 days from when the services are rendered.
If you are unable to pay the balance in full within the 30 day time period, please contact our billing specialist.

Methods of Payment

We accept Cash, Checks, Visa, MasterCard, Discover, Am Ex and Health Savings Account Debit Cards.

Returned Checks

We assess a $25.00 fee on checks that have been returned by our bank. We expect payment of the bank fee and the returned check before the next appointment.

Medicare Patients

Central Coast Eye accepts Medicare assignment. We will file to your secondary insurance, if you have provided us with the proper billing information. You are responsible for the applicable co-insurance, deductible, and non-covered services and injectable drugs. In addition to the bill we send to you, Medicare will also provide you with an Explanation with detailed information indicating the amounts you will owe. If you do not have any secondary insurance you are responsible for the balance after Medicare.

Medi-Cal Patients

Central Coast Eye accepts Medi-Cal assignment. A current Medi-Cal card must be presented at initial visit. You are responsible for obtaining prior authorization from your primary care physician for your initial visit. If you have a share of cost you will be required to make a payment on the day of service.

Minor Patients

The accompanying adult / guardian is responsible to pay for the services rendered to a minor patient. It is the responsibility of the person bringing the minor to the office to obtain reimbursement from any other source or parent. We will not bill another person regardless of any legal documents; it is the responsibility of the person with the minor patient at the time of service to resolve any issues with other parties.

Information Change

We ask that you please keep us informed of any updates to addressees, telephone numbers and insurance plans.

Collection Agency

Prompt payment of patient financial responsibility is expected per the terms of this agreement. We will use an outside collection agency for patient balances as we deem necessary. Failure to resolve outstanding patient balances may result in discharge from care by our physicians. Prior balances must be resolved before the practice will provide new services.

I have read and understand the financial policy of Central Coast Eye. I agree and understand the terms and conditions of this policy. I also understand that any questions I have, have been answered by the billing specialist to the best of my understanding.

Signature of Patient or Guardian of a minor: _____ Date_____

Print Name of Patient_____

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Due to rising practice expenses and demands on our staff, it has become necessary to institute the following charges. Please note that repeated no shows, rescheduling or failure to provide payment for services rendered may result in discharge from the practice for non-compliance.

Missed appointment without 24 hour notice: $25.00

Forms Fees

As a specialty practice, we are not always the appropriate provider to complete forms. Prior approval by the physician is required before a form is brought to our office for completion. We welcome phone calls to clarify our policy.

- Disability $25.00
- Jury Duty $25.00
- DMV Placard $20.00
- Typed Letters (any reason) $25.00
- Medical Records (depending on size) $16.00 and up
- Copies of Test Images $25.00
- DMV Form $25.00

Miscellaneous Fees

- Re-Billing Insurance due to Patient Error $25.00
- Returned Check $25.00

I understand that I am solely responsible for these fees as they are not covered by my insurance.

Patient signature: _____ Date: _____

Print name of patient: _____

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____

What is the main reason for your visit?: _____

_____

_____

_____

EYE HISTORY

A.	Do you have any of the following symptoms?			CIRCLE ANSWERS
	Blurred or reduced vision:	Distance	right	left
		Near	right	left
	Loss of vision:		right	left
	Blind spot in vision:		right	left
	Distortion in vision:		right	left
	Floaters / floating spots / cobwebs:		right	left
	Flashing lights / strobe lights:		right	left
	Light sensitive / glare / halos:		right	left
	Irritation / burning / itching:		right	left
	Eye pain:		right	left
	Dryness:		right	left
	Tearing / watering:		right	left
	Discharge:		right	left
	Redness:		right	left

B. Have you ever been diagnosed with?

Retinal Detachment / Tear

Macular Degeneration

Diabetic Retinopathy

Cataracts

Glaucoma

Eye Injury

Iritis / Uveitis

Other _____

C. Do you have a family history of?

Retinal Detachment / Tear

Macular Degeneration

Diabetes

Glaucoma

Cataract

Retinal Problems

High Blood Pressure

Other eye problem _____

D. Please list any eye surgeries and eye lasers you have had, include year of surgery:

_____ right left

_____ right left

_____ right left

_____ right left

E. Please list eye drops you are taking, also include over-the-counter drops, including doses and direction:

_____ right left

_____ right left

_____ right left

_____ right left

F. Do you take any Eye Vitamins - like "AREDS: formula vitamins (Preservision, I-Caps, etc.) and / or supplements. ncluding doses and direction

_____

_____

G. Do you wear glasses? If YES, please bring to your exam:

YES NO

Do you wear contact lenses? If YES, please be prepared to remove for your exam:

YES NO

GENERAL MEDICAL INFORMATION CIRCLE ANSWERS

A. Do you have a history of, or are you currently being treated for any of the following medical problems:

1. Constitutional:fever, weight loss, other _____ YES NO
2. Ears: reduced hearing or hearing loss YES NO
3. Nose / mouth / Throat: sinus problems, chronic cough YES NO
4. Cardiovascular disease: heart attack, hypertension YES NO
5. Respiratory disease: emphysema, asthma YES NO
6. Musculoskeletal: rheumatoid arthritis, lupus, arthritis YES NO
7. Dermatologic: rosacea, psoriasis, other skin rashes YES NO
8. Gastrointestinal: heartburn, GERD, acid reflux, diarrhea YES NO
9. Neurological: headache, migraine, TIA / stroke, paralysis YES NO
10. Psychiatric: depression, dementia, Alzheimer's Disease YES NO
11. Endocrine: diabetes _____year diagnosed, thyroid YES NO
12. Hematologic: anemia, anticoagulants, AIDS, HIV, Hepatitis YES NO
13. Genitourinary: male or female organ problems, urinary problems, kidneys YES NO
14. Allergic: hay fever, seasonal allergies YES NO
15. Cancer (type) _____ YES NO

B. Do you have a history of any major surgeries? Please list and include the year

_____

_____

C. Females, are you currently pregnant or nursing? YES NO

D. Do you have a Pacemaker or Defibrillator? YES NO

E. Please list ALL medications you are taking Including doses and direction:

_____
_____
_____
_____
_____
_____

F. Please list other vitamins and minerals you are taking: Including doses and direction

_____

_____

G. Please list ALL drug and food allergies / sensitivities (i.e. nuts, latex, tape)

_____

_____

_____

SOCIAL HISTORY

A. Please list your occupation: _____
(what environment are your eyes in?)

B. Do you drive? YES NO

If you stopped driving, was it because of your vision? YES NO

C: Do you use tobacco? YES NO

I authorize the physician and / or his technician at Central Coast Eye to dilate my pupils, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

Patient Signature: _____ Date: _____

Patient name (PRINTED CLEARLY): _____