Patient ID# _____

Date: _____

Lynn Polonski, M.D. **Ovette Villavicencio M.D., Ph.D.** **Leslie Weintraub, O.D.**
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WELCOME TO OUR OFFICE!

In order to complete a thorough evaluation of your eye health please allow 1 ½ - 2 hours for your visit.

Please fill out this form COMPLETELY to allow us to process your insurance. Thank you.

Patient's Name _____ Sex: M / F Single / Married / Widowed / Divorced

Age _____ Birthdate (MM/DD/YYYY) _____ Patient SS # _____

Patient's Address _____ City, State, Zip _____

Home Phone _____ Cell _____ Email Address _____

Race _____ Ethnicity _____ Preferred Language _____

Responsible Party Name _____Responsible Party SS # _____

Relationship to Patient: Self / Spouse/ Parent Is Patient: Employed / Student / Disabled / Retired

Employer Name / Address / Phone_____ Occupation: _____

Who can we speak with pertaining to your Health Care?

Name _____ Phone _____ Relationship_____

Name _____ Phone _____ Relationship_____

Referring Doctor Name & Address _____

Primary Care Doctor Name & Address _____

Primary Insurance _____ **Secondary Insurance** _____

Policyholder Name _____ Policyholder Name _____

Policyholder Sex: M or F Birthdate_____ Policyholder Sex: M or F Birthdate_____

Pharmacy _____Cross Streets _____Phone# _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Catalina Eye Care PC to release medical information requested by insurance companies and or correspondence with your other physicians.

This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing. **Patient's Initials _____**

Indicate any of the following medical problems in which you may have experienced:
(Please answer all)

High Blood Pressure	Y/N	Cholesterol	Y/N	Pregnant	Y/N	Asthma	Y/N
Heart Attack	Y/N	Irregular Heartbeat	Y/N	Seizures	Y/N	Pacemaker	Y/N
Arthritis	Y/N	Contact Lens	Y/N	Diabetes	Y/N	Thyroid	Y/N
Abdominal Pain	Y/N	Crohn's Disease	Y/N	Emphysema	Y/N	Tuberculosis	Y/N
Bladder/Kidney	Y/N	Sinus Problems	Y/N	Bronchitis	Y/N	Lupus	Y/N
Hepatitis A	Y/N	Hepatitis B	Y/N	Hepatitis C	Y/N	Fatigue	Y/N
AIDS/HIV	Y/N	Alcohol Use	Y/N	Smoke	Y/N	Seasonal Allergies	Y/N

Have you received the INFLUVAC (Flu) Shot? Yes / No When _____

Have you received the Pneumococcal (Pneumonia) Shot? Yes / No When _____

Have you fallen in last 6 months? Y/N When _____

Any other health problems we should be aware of (example; Family History, Other Medical Surgeries)?:
_____
_____

Eye medications presently taking: _____
_____
_____

How old is your current eyeglass/contact lens prescription? _____ Years/Months

Who performed your last eye exam? _____

Practice Name: _____ **Phone#**_____

Do you have any of the following or a history of the following?
(Please answer all)

Iritis	Y/N	Retinal Tear/Detachment	Y/N	Eye Injury	Y/N	Lazy Eye/Turned Eye	Y/N
Glaucoma	Y/N	Family history of Glaucoma	Y/N	Cataract	Y/N	Keratoconus	Y/N

Specify any other eye issues: _____
_____
_____

Have you ever had eye surgery? Y/N If yes, please explain: _____

MEDICATIONS:

Please list all current medications, Vitamins/Supplements and Aspiring products you are currently using:

Medication Allergies and reaction:

REFERRALS: I understand that obtaining a referral is my responsibility. If I am seen without the necessary authorization and/or referral, I understand that I am liable for all charges. **Patient's Initials** _____

VISION INSURANCE vs MEDICAL COVERAGE:

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses, help pay for eyeglasses or contact lenses, and to evaluate the health of their eyes. It is not designed or equipped to deal with medical conditions, diagnosis, and/ or treatment plans.

When a medical diagnosis or condition is present (such as high blood pressure, diabetes, or an eye disease such as infections, dry eyes, allergy, and cataracts, to name just a few) it is necessary to file the claim for your visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. Vision insurance does not cover medical eye problems, just as medical insurance does not cover routine vision problems. Our office does not make these rules; they are defined by the insurance carriers themselves.

There is no way to know prior to the examination which type of insurance will apply or with whom our office will be able to file a claim for you. We make every effort to be a provider on every major carrier for your convenience and we will file those claims for you when there is a medical problem. In the event that we do not take your major medical/ vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know. **Patient's Initials _____**

No Show/Late Cancellation Policy

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of $50.00 will be assessed for each no-show or late-cancellation office visit appointment if less than 24 hour notice is given____.(Initial)

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Signature: _____ Date: ___/____/____

Refraction Billing Policy

A refraction is conducted to measure the strength of the prescription for your glasses. A refraction is also an important tool that aids in the diagnosis and treatment of many eye conditions.

Most insurers, including Medicare, classify this as a “Non-Covered” Service and require that patients be responsible for payment. Federal guidelines require that refractions be billed separately for all patients.

Our staff is expected to collect payment for refractions, currently $50.00, on the day of service. This is in addition to any co-pay, deductible or other non-covered service charge you may have.

Patient Waiver and Authorization:
I understand that a refraction is a Non-Covered Service and agree to comply with the above policy. If I choose to have a refraction performed, I accept full responsibility for the cost of this service.

Patient Signature: _____ Date: ___/_____/_____

Catalina Eye Care, P.C.

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INSURANCE ADVANCE BENEFICIARY NOTICE (ABN)

***Insurance will only pay for services that it deems medically necessary.** If my insurance determines that a particular service, although it would otherwise be covered, is not reasonable and medically necessary, they may deny payment for that service. For instance, your insurance may likely deny payment for:

- **Refraction** $50.00
- **A-SCAN** $90.00
- **Topography** $40.00
- **OCT** $45.00
- **Pachymetry** $25.00
- **Pentacam** $65.00
- **Digital Retinal Image** $40.00

Please read and sign the following statement:

Most Insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. **I understand that I am responsible for any balance my insurance does not pay.**

Signed: _____. Date: ____/_____/_____

Witness: _____. Date: ___/_____/_____