ADV VISION

WELCOME TO ADV VISION

Who may we thank for referring you to ADV Vision?

☐ **Friend/Patient:** _____

☐ **Optometrist/OD:** _____

☐ **Physician/MD:** _____

☐ **Organization:** _____

☐ **Event:** _____

☐ **Staff Member:** _____

☐ **Other:** _____

☐ **Advertising: (*please circle*)**

Our Website, Internet, Mailer, Radio, T.V.

Other advertising_____

LAST NAME: _____ FIRST NAME: _____ M.I.:_____

MR./MRS./MS./MISS (circle) GENDER: ☐ M ☐ F PREFERRED NAME: _____

D.O.B.: _____ AGE: _____ S.S.N.: _____-_____-_____ MARITAL STATUS: _____

OCCUPATION: _____ HOBBIES: _____

PREFERRED LANGUAGE: _____ RACE: _____

ADDRESS: _____ APT./UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMPLOYER: _____

EMAIL ADDRESS:_____

PRIMARY INSURANCE: _____ Is patient covered by additional insurance? Y N

NAMED INSURED: _____ S.S.N. if not self: _____-_____-_____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____OPTOMETRIST: _____

Consent to treatment and financial agreement:

I hereby consent to and authorize treatment and medical services by Adam D. Abroms, M.D. and Paul J. Dougherty, M.D. and staff and agree to pay all charges incurred. I hereby authorize my insurance company to pay Dr. Abroms and Dr. Dougherty directly any medical, surgical, or major medical benefits due to me for services rendered. I authorize release of information requested by my insurance company regarding my treatment. It is the policy of this office that the parent who requests treatment for the child is responsible for all fees for services rendered.

Date: _____ Signature: _____

ADV Vision
MEDICAL HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ MI: _____

Briefly state the reason for your visit: _____

_____

Do you presently or have you had any problems in the following areas? If "YES," please explain.

	YES	NO	EXPLAIN
Eyes			
Redness	[ ]	[ ]	_____
Gritty feeling, dryness, or tearing	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eyes, eyelids, or sties	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Blurred vision or loss of vision	[ ]	[ ]	_____
Double vision	[ ]	[ ]	_____
Amblyopia (Lazy Eye)	[ ]	[ ]	_____
Blepharitis	[ ]	[ ]	_____
Cataract Surgery	[ ]	[ ]	_____
Corneal Abrasion or Ulcer	[ ]	[ ]	_____
Conjunctivitis (Pink Eye)	[ ]	[ ]	_____
Dry Eye Syndrome	[ ]	[ ]	_____
Trauma	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Herpes	[ ]	[ ]	_____
Kerataconus	[ ]	[ ]	_____
Retina (Tears, Holes, Detachment)	[ ]	[ ]	_____
Surgery	[ ]	[ ]	_____
Other (please list)	[ ]	[ ]	_____
Ears, nose, mouth, throat (hearing, sinus)	[ ]	[ ]	_____
Cardiovascular (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (asthma, lungs, breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach, intestines)	[ ]	[ ]	_____
Genitourinary (genitals, kidney, bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles, joints)	[ ]	[ ]	_____
Integument (skin, breast)	[ ]	[ ]	_____
Neurologic (stroke, paralysis, numbness)	[ ]	[ ]	_____
Psychiatric (depression, anxiety)	[ ]	[ ]	_____
Endocrine (thyroid, hormones)	[ ]	[ ]	_____
Hematologic (anemia, clotting problems)	[ ]	[ ]	_____
Immunologic (hay fever, lupus, HIV)	[ ]	[ ]	_____
Cancer (breast, lung, skin, colon, other)	[ ]	[ ]	_____
General (weakness, fatigue, weight loss)	[ ]	[ ]	_____

Please list any ALLERGIES to eye drops: _____

_____

Please list any eye drops currently using: _____

_____

_____

Please list all of the medications that you are currently using (except eye drops): _____

_____

_____

_____

Please list all major illnesses (such as diabetes, hypertension, hypercholesterolemia, etc.): _____

_____

_____

_____

Please list all major surgical procedures: _____

_____

_____

_____

Do you have any medication allergies? [ ] YES [ ] NO

If yes, please list all medication allergies: _____

FAMILY HISTORY: Does anybody in your family have or have had any of the following?

Eyes	**YES**	**NO**	**EXPLAIN**
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	_____
Retinal Detachment	[ ]	[ ]	_____
Medical			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____

SOCIAL HISTORY:

Eyes	**YES**	**NO**	**EXPLAIN**
Have you ever tried to wear contact lenses?	[ ]	[ ]	_____
Did you have any problems with contacts?	[ ]	[ ]	_____
Does your vision cause problem with…			
Driving?	[ ]	[ ]	_____
Reading?	[ ]	[ ]	_____
Sports/outdoor activities?	[ ]	[ ]	_____
General			
Do you drink alcohol?	[ ]	[ ]	How much per day? _____
Do you smoke?	[ ]	[ ]	How many cigarettes per day? _____
Do you drive?	[ ]	[ ]	_____

Patient's Signature: _____ **Date**: _____

Physician's Signature: _____ **Date**: _____

History Reviewed: [ ] No changes [ ] Additions as noted

Pre-Surgical Cataract Patient Questionnaire

Patient
Name _____
Chart Number _____
Eye Being Evaluated ☐ RT ☐ LT

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?	YES	NO
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
2. Reading a newspaper or book?	☐	☐
3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	☐	☐
4. Recognizing people when they are close to you?	☐	☐
5. Seeing steps, stairs or curbs?	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐
8. Writing checks or filling out forms?	☐	☐
9. Playing games such as bingo, dominos, or card games?	☐	☐
10. Taking part in sports like bowling, handball, tennis, or golf?	☐	☐
11. Cooking?	☐	☐
12. Watching television?	☐	☐

SYMPTOMS

Have you been bothered by:	YES	NO
1. Poor night vision?	☐	☐
2. Seeing rings or halos around lights?	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐
4. Hazy and/or blurry vision?	☐	☐

SYMPTOMS *(continued)*	**YES**	**NO**
5. Seeing well in poor or dim light?	☐	☐
6. Poor color vision?	☐	☐
7. Double vision?	☐	☐

DRIVING

1. Have you ever driven a car? ☐ YES *(continue)* ☐ NO *(stop)*
2. Do you currently drive a car? ☐ YES *(continue)* ☐ NO *(stop)*

3. How much difficulty do you have driving during the day because of your vision?
   - ☐ No difficulty
   - ☐ A little difficulty
   - ☐ A moderate amount of difficulty
   - ☐ A great deal of difficulty

4. How much difficulty do you have driving at night because of your vision?
   - ☐ No difficulty
   - ☐ A little difficulty
   - ☐ A moderate amount of difficulty
   - ☐ A great deal of difficulty

5. When did you stop driving?
   - ☐ Less than 6 months ago
   - ☐ 6-12 months ago
   - ☐ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

☐ **YES** ☐ **NO**

Patient Signature _____ Date _____

ADV VISION Date: _____ Name: _____

Lens Questionnaire

This questionnaire will assist us in providing the treatment best suited for your visual needs.

Occupation:_____

Hobbies:_____

1. Are you interested in seeing well **at distance** without glasses after surgery?
   ❑ **Prefer no distance glasses.** ❑ **I wouldn't mind wearing distance glasses.**

2. Are you interested in seeing well **at near** without glasses after surgery?
   ❑ **Prefer no reading glasses.** ❑ **I wouldn't mind wearing reading glasses.**

We divide vision into 5 "Zones of Vision"

Near ⟵ **Far**

Zone 1 (12-20 in.)	Zone 2 (2-4 ft.)	Zone 3 (6-20 ft.)	Zone 4 (20-100 ft.)	Zone 5 (100 ft.+)
Newsprint	Headlines	Indoors	Day-Far	Night-Far
Phone Book	Computer	TV	Driving	Night Driving
Maps	Menus	Cooking	Golf	Movies
Sewing	Price Tags	Cleaning	Road Signs	Star Gazing

3. **Zones of Vision:** Which group of "Zones of Vision" is the **MOST** important group to you? Please choose **only one** of the following three options of Group A, B or C:

   ❑ **Group A: Zones 1, 2 and 3** ❑ **Group B: Zones 2, 3 and 4** ❑ **Group C: Zones 3, 4 and 5**

4. If you **had** to wear glasses after surgery for one activity, for which activity would you be **most** willing to use glasses?
   ❑ **Reading fine print** ❑ **Computer** ❑ **Driving**

5. If you could have good **distance vision during the day** without glasses, and good **near** vision for reading without glasses, but the compromise was that you might see some **halos** around lights at night, would you like that option?
   ❑ **Yes** ❑ **No**

6. If you could have good **distance vision during the day and night** without glasses, and good **computer-distance (Zone 2)** vision without glasses, but the compromise was that you might need glasses for reading the finest print at near, would you like that option? ❑ **Yes** ❑ **No**

7. Do you currently have mono-vision (one eye corrected for distance, the other for near? ❑ **Yes** ❑ **No**

8. Do you do a lot of night driving? ❑ **Yes** ❑ **No**

9. Newer lenses are available that may allow you to see both distance and near to minimize the need for glasses. Would you be interested in these even though your insurance will not pay for it? ❑ **Yes** ❑ **No**

10. Please place an "X" on the following scale to describe your personality as best you can:

[----------|----------]
Easy going Perfectionist

Please Sign Here: _____

ADV VISION

HEALTH PLAN ELIGIBILITY FORM

Patient Name _____ Date of Birth _____

Subscriber's Name _____ Relation to patient _____

Subscriber's Social Security _____ Subscriber's Date of Birth _____

Primary Health Plan _____ PPO/HMO/MEDICARE/MEDI-CAL Type of Plan (Please circle)

_____/_____/_____ Effective date of coverage

Plan ID Number _____

Secondary Health Plan _____ PPO/HMO/MEDICARE/MEDI-CAL Type of Plan (Please circle)

_____/_____/_____ Effective date of coverage

Plan ID Number _____

I, the above named patient, hereby certify that I am eligible for medical coverage under the health plan and effective date listed above. I understand that if I am determined not to be eligible for the health care provided, I am liable for all charges for the services rendered. I agree that if I am not eligible, I (or the person financially responsible for me) will pay all charges in full within thirty (30) days of receiving notification.

Patient Signature _____ _____/_____/_____ Date

Financially Responsible Party Signature _____ _____/_____/_____ Date

ADV VISION

ADVANCE NOTICE OF DENIAL

A comprehensive medical eye examination should include a refraction for glasses. The refraction determines what your lens correction is for your glasses and/or contacts.

Most insurance companies deem a refraction as not medically necessary and will not pay for this portion of your eye exam.

The cash fee for the refraction is $45.00

SIGNATURE: _____

DATE: _____

I DO NOT WISH TO HAVE A REFRACTION

SIGNATURE: _____

DATE: _____

ADV VISION

MEDICAL RELEASE AUTHORIZATION

MEDICARE PATIENTS ONLY

Medicare requires that we have you sign a release of information and authorization to pay Adam D. Abroms, M.D. and Paul J. Dougherty, M.D. and/or his associates each year. Please complete this form so that we may bill Medicare and your contracted supplemental insurance for all examinations, treatments, in office procedures, and surgical services.

Patient name: _____

Medicare number: _____

If we are a contracted provider of your supplemental insurance company, we will bill them for you. If we are not contracted you may bill them yourself after you have received a Medicare Explanation of Benefits.

Supplemental insurance: _____

I.D. number: _____ Group Number: _____

In some instances Medicare may be your secondary insurance coverage.

Are you or your spouse working? (please circle) YES NO

If yes, please specify. (please circle) Myself Spouse

Employer: _____

Primary insurance company: _____

I.D. number: _____

I request that payment of authorized Medicare and contracted supplement benefits be made on my behalf to Adam D. Abroms, M.D. and Paul J. Dougherty, MD and/or his associates for services furnished by the physician. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical information about me to release it to the health care financing administration or its agents. I also authorize information needed to determine these benefits may be released to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

ADV VISION

Acknowledgement of Receipt of Notice of Privacy Practices

ADV Vision reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have received a copy of the Notice of the Privacy Practices for Dougherty Laser Vision.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient's Representative to Patient

Notice of Privacy Practices

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

Uses and Disclosures:

Treatment. Your health information may be used by staff members or disclosed to other health care professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support day-to-day activities and management of ADV Vision. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures Require your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of notice.

Dougherty Laser Vision Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending letter outlining your concerns to:

ADV Vision
4353 Park Terrace Drive, Suite #150
Westlake Village, CA 91361
Tel: (805) 987-5300
Fax: (818) 707-7668
www.doughertylaservision.com

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause or your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices are:

ADV Vision
4353 Park Terrace Drive, Suite #150
Westlake Village, CA 91361
Tel: (805) 987-5300
Fax: (818) 707-7668
www.doughertylaservision.com

Effective Date
This notice is effective on or after April 14, 2003