REINGOLD

EYE CENTER

New Patient Information Packet

12139 Riverside Dr.
Valley Village, CA 91607
818.763.EYES (3937)
www.reingoldeyecenter.com

Reingold Eye Center

Patient Registration Sheet <u>(Please Print)</u>

Patient Name: _____ Date: _____
(Circle one: Mr. Ms. Mrs. Miss)

Address: _____

_____
City State Zip

Home Phone: _____ Work: _____ Cell: _____

Cell Phone Carrier:_____ (*to receive an appointment reminder by text message*)

Social Security #: _____ Date Of Birth: _____

E-Mail: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ DP

Spouse / Parent Name: _____

Responsible Party: _____ Relationship: _____

Employed By: _____ Occupation:_____

Address: _____

Referred By: _____ Phone #: _____

Patient's Primary Care Physician: _____Phone #: _____

******In Case Of Emergency please contact*** (NAME): _____

Phone #: _____ Relationship: _____

Insurance: (Primary) _____

Secondary, if applicable: _____

I authorize the release of any medical information necessary to process this claim, and authorize the release of payment for medical benefits to my physician. I understand I am financially responsible to said doctor for all charges. We do not render services on the assumption that your charges will be paid by your insurance company.

I have been informed and understand that if my eyes are being dilated my vision will be blurred for approximately 4 hours and I may not be able to drive during this time.

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Date of last eye exam: _____

List any medications you currently take (Rx and over the counter) _____
Do you have any **allergies** to any medications? Yes No If Yes please list _____
List all major illnesses: (glaucoma, diabetes, high blood pressure, heart attack etc.) or injuries (concussions, etc.)
List **ALL** surgeries you have had (cataracts, appendectomy etc): _____

Do you **currently** have any problems in the following areas? If **YES**, please provide additional information.

	YES	NO	Details
Eyes (poor vision, eye pain, tearing, redness etc.)			
General / Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc,)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (upset stomach, diarrhea, constipation, hernia, ulcer, etc.)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
Females: Are you pregnant? Nursing?			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood / Lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
Allergic / Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History (Mother, Father, Grandparents, Sibling)

Has a member of your family had these diseases (circle one)? Yes No Unknown

Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other inheritable disease:

Social History

Does your vision limit any activities of daily living? (Driving, reading, sports, work, etc.)? Yes NO
Have you ever had a blood transfusion? Yes No
Do you drink alcohol? Yes No If Yes, how much? _____
Do you smoke? Yes No If Yes, how much? _____ How many years? _____

Physician's Signature: _____ Date: _____

REINGOLD EYE CENTER

Office Policy

All co-payments are due in full at the time of each visit.
A $25.00 additional fee will be charged if payment is not collected at time of service.

- **48 HOUR CANCELLATION POLICY** **$75.00**
  There will be a $75 charge applied if 48hr notice is not given to reschedule or cancel an appointment. All patient's credit cards will be kept on file.

Refraction, contact lens fitting, and evaluation fees are as follows:
(Medical insurance cannot be billed for these services, as they are not included as part of a comprehensive eye examination. Payment is due at the time of service.)

- **Refractions (prescription for glasses)** **$59.00**
- **Soft Contact Lens Evaluation and Over-Refraction-(*Prescription is good for one year)*** **$60.00-$145.00**
  For patients who have previously worn contacts and do not require training. All new Patients must bring a copy of their existing contact prescription, otherwise, it will be considered a new contact lens fitting and charged as such.
  New Contact Lens Fitting and Training-*(Prescription is good for one year)* **$125.00-$225.00**
  Applies to all 1st time contact lens wearers or NP that do not bring in an old contact RX
  Includes corneal topography, follow up contact lens checks up to 90 days from visit, and first pair of disposable contact lenses at the time of fitting.
  Disposable soft contact lenses only.--Please allow 1 hour (in addition to exam)
- **All glasses and contact lens rechecks past 90 days from the initial visit will be charged** **$59.00**
- **Additional training on insertion and removal of soft contact lenses** **$35.00**
- **Hard and Gas Permeable Contact Lens Fitting** **$250.00**
- **LASIK 2 Hour Exam** **$200.00**
  Patient's financial responsibility at the time of service. Surgery must be performed Within 30 days of exam. *ADDITIONAL CHARGE FOR MONOVISION TRIAL*
- **If dilation is deferred by the patient at the time of service and the patient decides to come back later for dilation, a new office visit fee will be charged at that time of service.** **$125.00**
- **Optical Policy** – Optical sales are **NON- RETURNABLE**. They are a custom order to fit each individual patient. We offer a one-time REDO within **30 days** from the date the glasses were purchased. If you are unable to adapt to a lens design, such as a progressive, we will happily remake it into another lens option like a bifocal or single vision lens at no additional charge. However, since this is a custom order the original cost of the lens will NOT be refunded. Restocking fee's up to 50% will apply to cancelled orders or orders not picked up. Orders left over 6 months will be dismantled or donated and the patient will be subject to 50% restocking fees on top of their insurance benefits, and or personal frames/lenses, etc being forfeited. Reingold Eye Center accepts no responsibility or liability on glasses mailed.
- **Surgery Cancellation/No Show Policy** **$500.00**
  There will be a $500 cancellation/reschedule charge if less than 2 weeks' notice is given to cancel your surgery.
- All Surgery costs are due to Reingold Eye Center the Friday before your scheduled surgery. This includes insurance deductibles, co-insurance, and any premium add on packages.
- **Release/Copy of patient records to patient** **$25.00 CLERICAL FEE + $0.25 PER PAGE COPIED**

I understand and agree to the above.

_____ _____
Patient signature Date

Version 8/1/2023

OFFICE FINANCIAL POLICY AND SERVICE CONTRACT

PLEASE INITIAL BESIDE EACH NUMBER

_____ 1. I understand that Warren J Reingold MD AMC will bill my insurance as a courtesy, but my patient portion (co-pays for office visits, deductible, and coinsurance for procedures) is my responsibility and due at the time of service. If your staff is unable to determine what my responsibility will be, I will be billed and my payment is due upon the receipt of the first invoice. An interest charge of 1.5% per month or 18% per year may also apply to delinquent balances. If your account is sent to an outside collection agency there will be a 30% fee added to your outstanding balance. This office policy is an effort to reduce costs related to our collection efforts so we can offer you more affordable healthcare overall.

_____ 2. I understand that if Warren J Reingold MD AMC is contracted with my insurance company, you will apply the contracted adjustment to my claims reducing my costs. If I have Medicare, you will file my secondary insurance. For both Medicare and other major insurances, I understand your staff will notify me of any services recommended for me that my insurance may not cover. I understand that these non-covered services that may be considered not medically necessary by my insurance are my responsibility and the contracted rate adjustment will not apply.

_____ 3. I authorize Warren J Reingold MD AMC to release any information to my insurance company, adjuster, or attorney involved in this case.

_____ 4. I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office operation.

_____ 5. If my insurance fails to pay my claim in a timely manner, I authorize Warren J Reingold MD AMC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ 6. I authorize payment be made by my insurance company directly to Warren J Reingold MD AMC. If my current policy prohibits direct payment to Warren J Reingold MD AMC, I hereby instruct my insurance company to make out the check to me and mail it as follows 12139 Riverside Dr. Valley Village, CA 91607. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

_____7. I authorize Warren J Reingold MD AMC to deposit checks received on my account for services rendered if they are made out in my name.

_____8. My primary insurance company _____, is responsible for this bill. I may have a secondary benefits with another insurance company, but primary responsibility for my claim is with _____ insurance company. A photocopy of this financial agreement shall be considered as effective and valid as the original.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

_____ _____ _____

Patient Name (Printed) Signature Date

REINGOLD
EYE CENTER

INSURANCE ELIGIBILITY WAIVER

It is important that prior to your visit at Reingold Eye Center, you confirm with your insurance carrier that we are in network with your particular plan. Due to there being multiple policies under each insurance it is your responsibility to know which provider and services are covered by your insurance policy. Please make sure you provide and update us if there is a change in your insurance before each office visit, so we can properly bill your insurance. Copayments are due and collected at the time of each office visit. Copayments are a part of your insurance contract, and we are REQUIRED to collect them. If you are not eligible for insurance benefits for today's visit, you will be financially responsible for the services performed by the doctor and receive a bill in the mail.

Billing

In order for you to receive your appropriate insurance coverage, two things must be provided correctly:

1. Up to date, accurate demographic information (address, phone numbers, etc.) and insurance policy numbers. Please make sure your demographic form is completed accurately.

2. Physical insurance cards for your current and active insurance coverage must be presented on the day or your appointment. We must have this, so we can bill the insurance company in a timely fashion. If the claims are denied non-coverage, you will be billed directly for payment. Once you provide current insurance information, we will be happy to bill the updated insurance provided if it falls within the filing limits of your new policy.

Referrals

If you need to be seen for services outside our office, your doctor will direct you to a provider that is best suited to handle your medical care. If that provider is not in network with your insurance, it is your responsibility to call your insurance to locate an in-network provider in the same specialty.

Missed Appointments

Our cancellation policy is 48 hours. There will be a $75 fee for any appointments not cancelled within that time frame. Please help us serve you better by keeping scheduled appointments or notifying us right away if you cannot keep an appointment.

I understand that if I am not eligible for insurance benefits for today's visit, I will be financially responsible for the services performed by the doctor.

_____ _____

Signature of Patient or Parent/Guardian Date

12139 Riverside Drive - Valley Village, CA 91607
Telephone: 818.763.EYES (3937) - FAX: 818.763.2331

Authorization to Disclose Protected Health Information (PHI)

This form allows certain entities/individuals to have access to your protected health information (PHI) per your approval. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name:_____ **Date of Birth**_____/_____/_____

I authorize the use and/or disclosure of Protected Health Information (PHI) as described below.

- Name of Organization (s) authorized to use, release or disclose the Protected Health Information: **REINGOLD EYE CENTER**
- Person (s) authorized to receive Protected Health Information:

  Name:_____ Relation:_____
  Phone number:_____

  Name:_____ Relation:_____
  Phone number:_____

Reingold Eye Center has my permission to use or disclose the following health information to the names listed above.
☐ All of my health information
☐ My health information relating to the following treatment or condition:
_____
☐ My health information covering the period of healthcare from (date) _____ to (date)_____
☐ Other:_____

This authorization ends:
☐ Will remain in effect until I submit in writing otherwise
☐ On this Date:_____

Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

***Signature of Patient or Authorized Representative:** _____ Date: _____

12139 Riverside Drive, Valley Village, CA 91607
818-763-3937 Fax: 818-763-2331

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Patient Name:_____ **Date of Birth**_____/_____/_____

Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

***Signature of Patient or Authorized Representative:** _____ Date: _____

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I have a right to inspect and/or receive a copy of the Health Information to be released and that I may be charged for any copies of the records that I receive. Access to health information created or obtained may be temporarily suspended until the chart note/review has been completed. Once completed, I will again have access to my health information.
If no prior notice to revoke this authorization is received, this authorization will not expire.
I will receive a copy of this authorization should I request it after I have signed it. A copy of this authorization is as valid as the original

***Patient Signature**: _____ **Date**: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age
☐ Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date: _____
Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:
☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____

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Pharmacy Information

This information will be used to expedite any prescriptions you may need filled. Please complete this form in its entirety. All information is needed.

Patient Name: _____

Pharmacy Name:_____

Pharmacy Phone Number: _____

Pharmacy Address: _____

_____

Patient Signature: _____ Date: _____