LERNER EYE CENTER

Hilary Jon Lerner, M.D. *Eye Physician & Surgeon*
Lisa Chang, M.D. *Eye Physician*
Farah Noory, O.D. *Optometrist*

"Modern Technology with Old-Fashioned Care"

Office of Appt: Concord San Ramon Pittsburg

Patient:_____Appointment Date/Time:_____

Welcome to Lerner Eye Center. We will do whatever we can do to make your visit with us a pleasant one. Although we strive to stay on time, occasionally circumstances beyond our control cause us to run a little late. We appreciate your patience during these times.

Please help us by bringing the following with you at the time of your exam:

1. All patient Questionnaires (3 pages) completely filled out and signed.
2. All insurance cards (primary and secondary, if applicable).
3. Referral/Authorization from Primary care physician, if your insurance requires you to have one. All HMO's must have one and Contra Costa Health Plan members. Please bring at time of appointment so appointment does not have to be rescheduled (not required for elective consultations).
4. Your co-pay or payment if you are a cash patient.
5. Your eyeglasses or current contact lens prescription.
6. A list of current medications you are taking.

For comprehensive eye exams we set aside about an hour and a half for you. Should you be unable to keep your appointment, ***please notify us within 24 hours, as we dislike charging $35.00 for missed appointments***. Also, we like to let our patients know in advance that very few insurances cover the eyeglass exam, or "refraction" and that fee of $70.00 would be due by the patient at the time of service.

We look forward to seeing you on the above date. Should you need directions, please visit our website at **www.lernereyecenter.com**.

SAN RAMON OFFICE
2333 San Ramon Vly. Blvd. #145
San Ramon, CA 94583
(925) 820-9600
(925) 820-9790

CONCORD OFFICE
2338 Almond Ave
Concord, CA 94520
(925) 685-1130
(925) 685-1162

PITTSBURG OFFICE
2260 Gladstone Dr., #4
Pittsburg, CA 94565
(925) 432-9300
(925) 432-9600

PATIENT INFORMATION FOR LERNER EYE CENTER

Last Name_____First Name _____M.I._____Age_____

Address _____City _____ Zip _____

Circle: Male Female SS# _____ - _____ - _____ Date of Birth _____/_____/_____

Cell Phone (_____) _____Work /Home (_____) _____ Student? Y N

E-mail address: _____ @ _____ . _____
☐ **Check here if you wish to receive e-mail newsletters**

Marital Status M W D S Occupation _____ Employer_____

How were you referred to our office? _____ Optometrist_____

PRIMARY CARE PHYSICIAN_____ Phone (_____) _____

RESPONSIBLE PARTY INFORMATION (subscriber)

Last Name _____First Name _____M.I. _____Age _____

Address _____City_____Zip_____

SS#_____ Home Phone(_____)_____DOB_____

Patient's relationship to responsible party: _____

Employer_____Employer Phone(_____)_____

PRIMARY INSURANCE ☐ HMO ☐ PPO ☐ Medicare Risk ☐ Private Medical Group _____

Insurance Carrier_____ Co-pay Amount$_____

SECONDARY INSURANCE ☐ HMO ☐ PPO ☐ Medicare Risk ☐ Private Medical Group _____

Insurance Carrier_____ Co-pay Amount$_____

VISION INSURANCE
Insurance Carrier_____ Co-pay Amount$_____

Assignment of Benefits I agree to have my insurance send all payments for services rendered at Lerner Eye Center directly to the office on the claim form. Furthermore, I agree to have any medical records copied and sent to my insurance company to facilitate getting a claim paid and processed. This assignment may be copied and used the same as an original document. By signing the below, I acknowledge that all information is true and that I am compliant with the assignment of benefits. **HIPAA-Patient Privacy Act *** I hereby acknowledge that I received a copy of this medical practice's NOTICE OF PRIVACY PRACTICES. I further acknowledgement that a copy of the current notice will be posted in the reception area, and I will be offered a copy of any amended notice of Pricacy Practices at each appointment.

*May we speak to anyone at your home or leave a message on your machine.Y OR N

Patient Signature*_____ Date_____

*ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA) *

LERNER EYE CENTER FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your responsibility. We ask all patients to fill out our "*Confidential Patient Information*" form before seeing the doctor. We accept cash, check, Visa and Mastercard for your convenience.

INSURANCE WITH WHICH WE CONTRACT: (HMO, PPO, EPO, POS)

Because we participate with your insurance company we will handle the billing of your insurance claims. **Co-payments, deductibles, and non-covered services (such as refraction, contact lenses, glasses, etc.) will be collected at the time services are rendered.** Because ophthalmology is a medical specialty, some insurance companies require you to obtain a **REFERRAL/AUTHORIZATION** from your primary care physician or the company itself. **THIS IS NECESSARY FOR HMO INSURANCES.** This is a requirement by your insurance and we may need to reschedule your appointment if the proper documents are not obtained by the date of your appointment. Your insurance should pay our claims within 60 days of submission. If they do not, you agree to take an active part in getting this claim paid and that after 90 days of submission, assuming our office has completed all necessary information, you agree to pay the claim in full and pursue your insurance on your own.

PRIVATE INSURANCE and PRIVATE PAY

This type of insurance is a contract between the patient and the insurance company. We will assist you in receiving your maximum benefits, and will be happy to supply your insurance company with factual information as necessary with your permission. We ask that you pay for services rendered unless prior arrangements have been made with the office manager.

MEDICARE

We are participating with the Medicare/Palmetto. We will do all of the billing to Medicare and we receive payment directly from Medicare. If you have a secondary insurance, we will bill the secondary carrier as well. **You are responsible for any non-covered services such as refraction, contact lenses, glasses, etc.** Deductibles are also the patient's responsibility.

MINORS

Patients under the age of 18 should come to all appointments accompanied by a parent. The parent who signs the financial policy is responsible for payment of services. In the event the minor comes unaccompanied to our office, we must have a note of authorization for treatment as well as payment for services rendered.

I have read and understand the financial policy of Lerner Eye Center and assume the responsibility for payment of all services and materials.

***Signature*_____*Date*_____**

What problems do you feel you have with your eyes at this time?

_____

_____

Do you use eye drops? ☐ Y (please list below) ☐ N

_____ how many times a day _____

_____ how many times a day _____

_____ how many times a day _____

Please list all medications you are currently taking for:

Heart_____ _____

Diabetes_____

High Blood Pressure_____

High Cholesterol_____

Vitamins_____

Anxiety/Depression_____

Other Medications_____

_____ for _____

☐ I deny taking any medications ☐ List of medications attached

Have you had eye surgery? ☐ Y (please list below) ☐ N

Procedure Date by what doctor?

_____

_____

_____

_____

_____

Do you have a family history of any of the following?

Heart Disease ☐ No ☐ Yes-who? _____

Diabetes ☐ No ☐ Yes-who? _____

Glaucoma ☐ No ☐ Yes-who? _____

Cataracts ☐ No ☐ Yes-who? _____

Do you have any of the following health problems?
(Please check all that apply and provide any additional information) ☐ Y (complete below) ☐ N

Diabetes? ☐ Y ☐ N If Yes, How long? _____Years

Is your diabetes under control? ☐ Y ☐ N _____

Heart trouble ☐ Y ☐ N _____

High Blood pressure ☐ Y ☐ N_____

High Cholesterol ☐ Y ☐ N _____

Stroke (when?) ☐ Y ☐ N _____

Heart Attack (when?) ☐ Y ☐ N _____

HIV ☐ Y ☐ N Hepatitis ☐ Y ☐ N
TB ☐ Y ☐ N Cancer ☐ Y ☐ N

Other health problems? _____

_____

_____

Have you ever been hospitalized or had surgery?
☐ Y (List illness/surgery with dates below) ☐ N

_____ month & year _____

_____ month & year _____

_____ month & year _____

_____ month & year _____

Allergies to Medications: (please list below): ☐ Y (I have listed below ☐ No, I deny having any allergies

_____

_____

Patient Signature_____

Patient Name_____

For Office Use Only			
Medical update: Date and Initial.			