Los Angeles Vision Institute
8635 West Third Street, Suite 360W
Los Angeles, CA 90048
310.657.2777.office 310.657.0356.fax

Dear Patient:

The purpose of this letter is to help make your visit to Los Angeles Vision Institute more efficient and pleasant.

You should plan on being at Los Angeles Vision Institute for 1-1.5 hr, depending on the extent of your examination and any additional tests or studies that may be required.

EYEGLASSES
Please bring your best or most recent eyeglasses with you, even if they no longer improve your vision. They will provide important information about the past condition of your eyes.

DILATION
Your pupils might be dilated during your examination. Dilation lasts several hours and most people find that it blurs their vision.

LOCATION and PARKING
Enter the parking structure for Cedars West Tower from George Burns Drive. Parking in the structure can be as much as $20. Our building is located between Robertson Blvd & La Cienega Blvd on West Third Street, two blocks West of the Beverly Center.

From the parking structure, take the parking elevator to the third floor, and enter the West Tower building. Make a left just past the elevators inside the West Tower. We are located in suite 360W on the right.

PAYMENT
We accept assignment on Medicare. If your are a Medicare beneficiary and do not have secondary insurance, you will be responsible for payment on 20% of the allowed amount. If you are insured through an HMO, you must have a referral for every visit from your HMO primary care doctor. For selfpay cases, payment will be requested at the conclusion of the visit. Most insurance plans will not pay for the examination for glasses (refraction). Therefore, if you want to be evaluated for glasses, you will be responsible for a **$50** refraction fee. We accept payment by cash, check, Visa, MasterCard, or American Express.

Dr. Macy and Dr. Knezevic
Dr. Macy is a Comprehensive Ophthalmologist with a special interest in refractive surgery. He received his medical school training at Boston University School of Medicine and his ophthalmology specialty training at Doheny Eye Institute, USC. Dr. Knezevic is a Cornea Specialist who practices comprehensive ophthalmology. He received his residency training at Northwestern University and his fellowship training in Cornea, Anterior Segment, and Refractive Surgery at the University of California, Irvine.

FURTHER INFORMATION
If you have any questions prior to your examination, you may contact the Los Angeles Vision Institute office at (310) 657-2777.

We look forward to meeting you.

Office Staff at Los Angeles Vision Institute

ANSWERS TO FREQUENTLY ASKED QUESTIONS
ABOUT BILLING AND COLLECTION

You will be responsible for a refraction fee of **$50** if you are tested for eyeglass prescription. Vision insurance will cover one refraction per year. We are only contracted with two vision plans, Vision Service Plan (**VSP**) and EyeMed.

Please let the Front Office personnel know if you have vision coverage.

SELF PAY
If you are not covered by medical insurance, you will be expected to pay in full at the time of service by means of cash, check, or credit card.

INSURANCE
Be prepared to pay your deductible and co-payment. Please refer to your insurance handbook for co-payment and deductible rules.

If you are a member of an HMO, please bring your appointment authorization with you or have your primary care physician fax it to our office at 310.657.0356. If you are covered by an HMO and fail to bring the authorization, you may be asked to pay in full for the visit and any laboratory charges that are incurred at the time of service.

Some services may not be covered by your insurance. In this event you will be responsible for the charges. Please refer to your handbook or contact your member services for assistance with covered benefits.

MEDICARE
We accept assignment on Medicare. This does not mean that what Medicare pays is accepted as payment in full. You will be expected to pay for any non-covered services (such as the refraction charge of **$50**) as well as any deductible or co-payment, if applicable, at the time of service. If the visit results in a non-medical diagnosis, you will be responsible for the entire charge.

If you are a Medicare patient and do not have supplemental insurance, you will be responsible for the 20% that Medicare does not pay. It is against federal law and Medicare policy for the doctor to write off a deductible or any remaining balance. We are not permitted to extend professional courtesy.

If you are a Medicare patient with supplemental insurance, we will bill both Medicare and your secondary insurance. For any service not covered by the secondary insurance, you will be responsible for the charges.

Medicare patients who assign their benefits to an HMO are responsible for payment in full if the visit and associated laboratory tests are not authorized.

GENERAL INFORMATION
Laboratory tests are not included in the doctor's fees. Should you need laboratory testing, these will be performed and billed separately.

The faculty and staff at the Los Angeles Vision Institute hope this information is helpful to you in understanding our billing process.

Thank you for selecting the Los Angeles Vision Institute for your eye care 310.657.2777.

Los Angeles Vision Institute

Date: _____

Patient Name: _____
Last First Middle

Address: _____
Street City State/Zip

Home Phone: _____ Cell #: _____

Date of Birth: ____/____/_____ Age: _____ Male -or- Female (circle one)

Social Security #: _____ Driver License #: _____

Email Address: _____

Employer: _____ Work #: _____

Employer Address: _____
Street City State/Zip

Occupation: _____

Emergency Information

Emergency Contact Name: _____

Telephone #: _____ Relationship: _____

Insurance Information

Do you have a **Vision** Plan? **NO** -or- **YES** (if yes, name of plan) _____

Vision Plan Member Name, DOB and ID#: _____

_____

Relationship to Patient: _____

Is your **Medical** Insurance **HMO** –or- **PPO** –or- **MEDICARE** – or- **MEDI-CAL Only** –or - **SELFPAY**

Medical Plan Member Name, DOB and ID#: _____

_____

Relationship to Patient: _____

Referred By

(**If other than Physician**): _____
Name Relationship

Referred by Physician: _____
Name Phone Number

_____
Address City, State, Zip

Primary Care Physician: _____
Name Phone Number

Patient Signature: _____ **Date:** _____

Release Information/Records: I/We the patient/authorized representative, do hereby authorize Los Angeles Vision Institute or representative agents to release any information from the patient's records which may be required in connection with the collection of an account, claim for aid, insurance, or medical assistance to which the patient may be entitled.
Payment: Fees for professional services rendered are made payable to Los Angeles Vision Institute. The patient/authorized representative authorizes payment of all insurance benefits to be made directly to Los Angeles Vision Institute and agrees that it may receipt for any such fees not paid pursuant to the assignment.

Medical History Questionnaire

Please describe the reason for your visit to the doctor: _____

_____

How old is your current eyeglass prescription? _____

Have you ever had eye surgery? ☐ Yes ☐ No ☐ Left ☐ Right

Surgeon: _____

Type of Surgery: ☐ Cataract ☐ Glaucoma ☐ Retina ☐ Refractive ☐ Other

Please list any other surgeries: _____

Check any current eye diseases: ☐ Lids ☐ Cornea ☐ Conjunctiva ☐ Cataract
☐ Glaucoma ☐ Retina ☐Other

Do you have any of the following? (Mark "Yes" or "No".)

	Yes	No		Yes	No
Environmental Allergies	☐	☐	HIV	☐	☐
High Blood Pressure	☐	☐	Hepatitis	☐	☐
Heart Problems	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Bleeding Tendencies	☐	☐	Skin Problems	☐	☐
Rheumatoid Arthritis	☐	☐	Anxiety/Depression	☐	☐
Asthma	☐	☐	Cholesterol	☐	☐

Do you smoke? ☐Yes/☐No
Do you drink? ☐Yes/☐No
Any hazardous pastimes? ☐Yes/☐No
Are you pregnant? ☐Yes/☐No

Have any blood relatives had the following?
Glaucoma ☐Yes/☐No
Other eye diseases ☐Yes/☐No

Eye Medications: _____

_____

Systemic Medications: _____

_____

Allergies to Medications: _____

Thank you for completing our questionnaire.

REFRACTION

Refraction is the portion of the eye examination in which lenses are used to determine your best vision. Without refraction, it is impossible to determine your eyeglass or contact lens prescription. The refraction fee is $50. Most medical insurance companies do not cover refraction. This fee is the patient's responsibility and will be collected at the time of service. Vision insurance will cover one refraction per year. We are contracted with two vision plans, EyeMed and Vision Service Plan (VSP). Please let the Front Office personnel know if you have vision coverage.

If you do not want a refraction to determine if new glasses would be beneficial, please inform the ophthalmic technician and the refraction will not be performed. If refraction is not performed, you will not be charged the $50 fee. The remainder of the examination will be completed in its entirety.

When we bill Medicare (or other insurance companies) for an eye examination, we are required to itemize separate charges for the medical examination and the refraction. Unfortunately, Medicare and most other insurance carriers uniformly deny payment of the $50 refraction charge as a "non-covered" service. If it is determined, at a later date, that the refraction was a covered service, your payment will be promptly refunded.

Signature _____ Date _____

DILATING EYE DROPS

Dilating drops are used to enlarge the pupils of the eyes to allow a better view of the inside of the eye. Many conditions of the eye, such as cataract and macular degeneration, cannot be evaluated thoroughly without a dilated pupil.

Dilating drops usually blur vision for a length of time which varies from person to person. It is not possible for us to predict how much your vision will be affected or how long the effect will last. After dilation, driving may be more difficult, so it is best if you make arrangements not to drive yourself. If you choose to drive, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others.

Adverse reactions, such as allergy, fainting or acute angle-closure glaucoma, may be triggered by the dilating drops. Such reactions are extremely rare and are usually treatable with prompt medical attention. Acute angle closure glaucoma is an emergency which may result in vision loss. Should you develop signs or symptoms of acute glaucoma, such as eye pain and blurrier vision, call the office immediately or go to an emergency room.

I authorize the personnel of the Los Angeles Vision Institute to administer dilating eye drops.

_____ _____

Patient (or person authorized to sign for patient) Date

AUTHORIZATION FOR SERVICE

This signed document serves as general authorization for the following:

I am aware that I am responsible for any fees not covered by my insurance, i.e.; insurance copay, insurance deductible, or refraction fee (if or when applicable).

Self-Pay: I realize that I am fully responsible for any and all fees for services rendered.

Authorization to Bill Insurance: I have provided Los Angeles Vision Institute with a copy of my current insurance coverage and authorize them to submit the bill for services rendered.

Authorization for Treatment: I authorize for ophthalmic examination and treatment, if necessary, by Los Angeles Vision Institute.

HMO Patients: Prior to your evaluation at Los Angeles Vision Institute, certain insurance carriers (HMO) require authorization/approval from your Primary Care Practitioner (PCP) before they will pay for services.

It is your responsibility to know if your carrier requires authorization, and, it is also your responsibility to request and obtain this authorization before coming in for your visit. The authorization is a printed document that can be faxed before the exam date, or that you can bring with you on the date of service.

If an HMO patient does not have authorization for services, her/she is personally responsible for payment-in-full for services rendered. HMO patients can request authorization from their PCP after the examination (retro-authorization). The undersigned fully understands that he/she is personally responsible for payment for all services rendered **if** they do not have authorization at the time of services.

Signature _____ Date _____

HIPAA

NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact us.

I hereby acknowledge that I have been presented with a copy of the Los Angeles Vision Institute Notice of Privacy Practices.

Los Angeles Vision Institute
8635 W. Third Street, Suite 360W
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310-657-2777

Signature _____

Date _____

Name of Patient _____