EYECARE ASSOCIATES
OF SAN FRANCISCO

WELCOME TO EYECARE ASSOCIATES OF SAN FRANCISCO

Thank you for choosing **EyeCare Associates of San Francisco** for your eye care needs. Our ophthalmologists and optometrists are happy to share their passion for eye care with you.

Please take the time to read and complete the enclosed forms:

- Confidential contact and health history form
- Financial policy
- Notice of Privacy Practices and Acknowledgement form

These documents provide us with a comprehensive picture of your health status and a greater ability to address your eye health concerns. Please bring your completed forms along with your picture ID and insurance card(s) to your visit. Please use a separate sheet if needed to provide a complete list of current and historical medications. For your convenience we have posted our New Patient forms and Notice of Privacy Procedures on our website at www.eyecaresf.com.

MEDICAL ASPECTS

Your visit may last 1-3 hours, depending upon the specialized tests or procedures required. Please bring your current medications and your current eyeglasses with you to your appointment. If you have diabetes, please be sure to eat your regular meal or bring a snack.

Before seeing your doctor, you will be evaluated by an ophthalmic technician and/or an optometrist who may need to dilate your pupils. Pupil dilation will make it difficult for you to see at near but your distance vision should be adequate to drive, if you so choose. It may be advisable to bring a driver. We do advise that you bring your sunglasses. The effects of dilation usually wear off in a few hours; however, they may last as long as 24 hours.

Eyecare Associates of San Francisco

CONFIDENTIAL CONTACT FORM

LAST NAME: _____ **FIRST NAME**: _____

Address: _____ **City**:_____**State**:_____ **Zip:** _____

Primary Ph#:_____ **Secondary Ph#**:_____**SS# (last 4 #s okay)** _____

DOB: _____ **Age:** _____ **Sex:** **Marital Status** _____**Preferred language**: _____

Ethnicity: _____ **Do you drive?** Y ☐ /N ☐

EMPLOYER: _____ **OCCUPATION:** _____

Work Phone#: _____ **E-Mail:** _____

May we contact you by e-mail: (Check one) YES ☐ NO ☐

COMMUNICATION

What is the best way to communicate with you between office visits?

(Check One) ☐ E-mail ☐ Home Phone ☐ Work Phone ☐ Mobile

Is there any place you do NOT want us to leave a message? _____

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

Please initial one of the following statements:

_____ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

_____ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.

_____ I do not consent to receiving any information via email or text. I understand that I can change my mind and provide consent later.

Person to contact in case of emergency:

Name: _____ **Phone:** _____ **Relation to patient:** _____

Name: _____ **Phone:** _____ **Relation to patient**: _____

Primary Care Physician: _____ **Phone #:** _____

Optometrist: _____ **Phone #:** _____

How were you referred to Eyecare Associates: _____

UNION SQUARE: 360 Post Street, Suite 1005, San Francisco, CA 94108 P. 415-982-2020 F. 415-982-2011
STONESTOWN: 595 Buckingham Way, Suite 448 San Francisco, CA 94132 P. 415-564-1060 F. 415-564-3368
www.eyecaresf.com

Eyecare Associates of San Francisco

I give Eyecare Associates permission to discuss my health information with the following health care provider(s) and/or family member(s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship**: _____

INSURANCE INFORMATION

Vision Insurance:☐**VSP** ☐**MES** ☐**EYEMED** ☐**OTHER:** _____

Medical Insurance: _____ **Phone #:** _____

Member ID#: _____ **Group #:** _____

Patient relationship to policy holder:SELF☐/SPOUSE☐/DOMESTIC PARTNER☐/ PARENT☐

Secondary (if applicable):

Medical Insurance: _____ **Phone #:** _____

Member ID#: _____ **Group #:** _____

Patient relationship to policy holder: SELF☐/SPOUSE☐/DOMESTIC PARTNER☐/ PARENT☐

Please provide copies of all cards at check-in

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

1. I, the undersigned, realize that all medical and surgical charges incurred are my financial responsibility and hereby authorize ECASF to bill my insurance on my behalf. I hereby authorize the release of medical information to my health and/or vision plan or its intermediaries any information needed for this or related claim. A photocopy of this document shall be as valid as the original. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

2. I understand that I am financially responsible to ECASF for deductibles, co-payments, and any services not covered by my insurance(s).

3. I acknowledge that I have been given a copy of ECASF Notice of Privacy Practices.

I HAVE READ THE ABOVE AND AGREE TO ABIDE BY ITS TERMS AND FURTHER ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLY TO ECASF.

_____ _____

Signature **Date**

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History and Intake Form

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other _____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right☐, Left☐, Bilateral☐)
- ☐ Lumpectomy (Right☐, Left☐, Bilateral☐)
- ☐ Breast Biopsy (Right☐, Left☐, Bilateral☐)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right☐, Left☐, Bilateral☐)
- ☐ Joint Replacement, Hip (Right☐, Left☐, Bilateral☐)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right☐, Left☐)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis Ovaries
- ☐ Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer Prostate
- ☐ Removed: Prostate Cancer Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right☐, Left☐, Bilateral☐)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ **None**
- ☐ Other _____

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Ocular History: (please check all that apply)

- ☐ Allergic conjunctivitis
- ☐ Blepharitis
- ☐ Cataract (Left eye☐, Right eye☐)
- ☐ Corneal dystrophy (Left eye☐, Right eye☐)
- ☐ Diabetic retinopathy, background (Left eye☐, Right eye☐)
- ☐ Dry eyes
- ☐ Glaucoma (Left eye☐, Right eye☐)
- ☐ Maculardegeneration (Left eye☐, Right eye☐)
- ☐ Macular ERM (Left eye☐, Right eye☐)
- ☐ Narrow angles (Left eye☐, Right eye☐)
- ☐ Ocularhypertension (Left eye☐, Right eye☐)
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal tear (Left eye☐, Right eye☐)
- ☐ Strabismus
- ☐ PVD (Left eye☐, Right eye☐)
- ☐ Vitrous floaters (Left eye☐, Right eye☐)
- ☐ **None**
- ☐ Other_____

Ocular Surgery: (please check all that apply)

- ☐ Blepharoplasty (Left eye☐, Right eye☐)
- ☐ Cataract surgery (Left eye☐, Right eye☐)
- ☐ Corneal transplant (Left eye☐, Right eye☐)
- ☐ DSAEK (Left eye☐, Right eye☐)
- ☐ Eye Muscle Surgery
- ☐ Intravitreal injections (Left eye☐, Right eye☐)
- ☐ LASIK (Left eye☐, Right eye☐)
- ☐ LPI (Left eye☐, Right eye☐)
- ☐ LTP (Left eye☐, Right eye☐)
- ☐ PRK (Left eye☐, Right eye☐)
- ☐ Ptosis repair (Left eye☐, Right eye☐)
- ☐ Punctal plugs (Left eye☐, Right eye☐)
- ☐ Strabismus surgery
- ☐ Renital laser (Left eye☐, Right eye☐)
- ☐ Trabeculectomy (Left eye☐, Right eye☐)
- ☐ Tube shunt (Left eye☐, Right eye☐)
- ☐ Yag capsulotomy (Left eye☐, Right eye☐)
- ☐ **None**
- ☐ Other _____

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Family History: (please check all that apply)

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ CVA
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Macular degeneration
- ☐ Migraine
- ☐ Retinal detachment
- ☐ Strabismus
- ☐ **None**
- ☐ Other _____

Medications: (Please list all current medicatons)

_____

_____

_____

Do you give EyeCare Associates of San Francisco consent to import your medication history as provided by SureScripts: YES ☐ / NO ☐

Preferred Pharmacy _____ **Phone#**_____

Allergies: (Please enter all allergies)

_____

_____

_____

_____

Social History: (Please check all that apply)

Cigarette Smoking:

- ☐ Never smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Alcohol Use:

- ☐ Alcohol: none
- ☐ Alcohol: less than 1 drink a day
- ☐ Alcohol: 1-2 drinks a day
- ☐ Alcohol: 3 or more drinks a day
- ☐ **None**

Other_____

Eyecare Associates of San Francisco

IMPORTANT FINANCIAL POLICY

The goal of our practice is to provide a full-range of efficient and quality ophthalmological and optometric care to all our patients. In order to provide comprehensive vision services, we ask that patients provide their medical and vision insurance coverage information at the time of registration and to update us of any changes in coverage and contact information. It is the member's responsibility to verify eligibility, benefits and provider status.

One important part of your eye exam is the Refraction. The refraction determines your eyeglasses prescription and allows the doctor establish your best visual acuity and gives us vital information as to how your eyes are functioning. Refractive services are billed using a separate procedure code to **VISION INSURANCE PLANS IF AVAILABLE. Refractions are NOT COVERED under Medicare and most medical insurance plans including Brown and Tolland and Hill Physicians.** Unless we have specific proof of coverage, you will be charged a fee of **$90.00 for refraction services payable at the time of service**.

☐ YES, I WANT A REFRACTION ☐ NO, I DO NOT WANT A REFRACTION

1. Please note that contact lens exam services are NOT considered a routine part of your exam and there are additional fees for these services. Please see additional form provided for a schedule of fees.
2. Medicare beneficiaries are responsible for the yearly Medicare deductible which is $185.00 for 2020. We will also collect 20% of fees for all services provided at the time of service if no secondary coverage is available.
3. Our providers and staff will be happy to provide you or your physician with a copy of your Medical Records and/or to complete any governmental or employer issued forms in a timely fashion. The fee for this service is $25.00 due upon completion.
4. Due to the difficulty and unreliability in collecting fees from out-of state and traveler's insurance companies we will collect fees for services provided from all patients that are visiting from out of state or out of the country. We will bill your insurance as a courtesy and reimburse you if the services are covered.

Patient signature _____ Date _____

(I have read and understand the above financial policy. I agree to abide by its terms.)

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