Nimesh Pathak, MD
Cornea|Cataract|Refractive Surgery
5175 E. Pacific Coast Highway, Suite 102
Long Beach, CA 90804
p: 562.431.2748

Today's Date: ________________________ How are you feeling today: ____

Hobbies/Interests: ____

Patient Name: _______________________ Date of Birth: _____________________

Referring Physician: _____________________________________ Phone Number: _________________________________

Primary Care Physician: __________________________________ Phone Number: _________________________________

Optometrist: ____ Phone Number: ___________________________

How did you hear about us: Physician Our Website Internet Site/Ad_______________ Friend ______________

PATIENT INFORMATION

Gender: Female Male Social Security #: ___________________ Marital Status: _________________________

Email Address: _____________________________ Mailing Address: ____

City/State/Zip Code: ____

Home Phone: __________________ Cell Phone: ___________________ Work (if applicable): _______________________

Occupation: _____________________________ Pharmacy: ______________________ Phone: ________________________

Emergency Contact:____ Phone number: ____________________

Do we have permission to take your picture to associate with your medical records?

Yes **No**

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MEDICAL HISTORY

Medications and (Eye Drops- Prescription/Over The Counter): (please list): ________________________________

____

____

Allergies to any Medications: (please list): ____

Do you wear Contact Lenses: Yes / No   Glasses: Yes / No   If YES (Type:) ____________________________?

Have you had LASIK, PRK, RK: ____ DATE: _____________________________

Have you had any eye surgeries: ____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS: (Circle)

LOSS OF VISION	POOR VISION	EYE PAIN	DIABETES
TEARING	REDNESS	FEVER	ANEMIA
COUGH	SHORTNESS OF BREATH	HIGH BLOOD PRESSURE	ALLERGIES
UPSET STOMACH	JOINT PAINS	HEADACHE	RASH

MEDICAL HEALTH: (Circle)

ARTHRITIS	DEPRESSION	HYPERTHYROIDISM
ASTHMA	HEARING LOSS	PROSTATE CANCER
BPH	HEPATITIS	SEIZURES
BREAST CANCER	HYPERTENSION	STROKE
COPD	HIV/AIDS	ATRIAL FIBRILLATION (IRREGULAR HEARTBEAT)
CORONARY ARTERY DISEASE	HYPERCHOLESTEROLEMIA	

"OTHER":____

Do you smoke?	YES	NO
Do you drink?	YES	NO
Do you use drugs?	YES	NO

EYE HEALTH: (Circle)

ALLERGIC CONJUNCTIVITIS	NARROW ANGLES (RIGHT/LEFT/BOTH)
BLEPHARITIS	GLAUCOMA SUSPECT (RIGHT/LEFT/BOTH)
CATARACT (RIGHT/LEFT/BOTH)	OPHTHALMIC MIGRAINE
CONTACT LENSES (RIGHT/LEFT/BOTH)	RETINAL TEAR (RIGHT/LEFT/BOTH)
DRY EYES	CROSSED EYES
GLASSES	FLOATERS (RIGHT/LEFT/BOTH)
GLAUCOMA (RIGHT/LEFT/BOTH)	
MACULAR DEGENERATION (RIGHT/LEFT/BOTH)	

Please list any other diseases below:

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Authorization for the Use or Disclosure of Protected Health Information (HIPAA)

Our Notice of Privacy Practices provides information about we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office by mail at 5175 E. Pacific Coast Highway, Suite 102, Long Beach, CA 90804, phone at 562.431.2748 and email at info@lucentvision2020.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands the following:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent agree that Dr. Nimesh Pathak, MD (Lucent Vision), may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefits payers for treatment purposes.

Patient Signature:____Date: ___________________________________

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Dr. Nimesh Pathak, MD. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that I am financially responsible for all charges not paid by said insurance, including, but limited to, non-covered services, such as refractions, certain diagnostic tests, and cosmetic procedures.
A photocopy of this assignment is to be considered as valid as an original. The assignment will remain in effect until revoked by me in writing.

Patient Signature:____Date: ___________________________________

Consent for Treatment

I authorize, Nimesh Pathak, M.D., to provide me with medical care consistent with reasonable and current community standards. (If patient is under 18 years of age - must be signed by parent and/or legal guardian)

Patient Signature:____Date: ___________________________________

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Financial Policy

Thank you for choosing Lucent Vision as your eye care specialist! Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have created this financial policy to better assist you. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. Our participation with your insurance plan will be verified during your registration for each office visit. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. We will do our very best to help you understand your coverage, but knowing your insurance benefits is ultimately your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will always notify you of non-covered services before they are rendered. You must pay for these services in full either at the time of the visit, or within a pre-arranged time frame.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

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5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In addition, delinquent accounts that are referred to a collection agency will incur an additional 25% surcharge. Should this occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Lucent Vision is committed to providing the most compassionate treatment to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns!

I have read and understand the payment policy and agree to abide by its guidelines

Signature of patient or responsible party

_________________________ _________________________ ________

Patient Name Patient Signature Date

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Appointments Policy

We are committed to providing you with compassionate eye care in a timely fashion. In order to maximize your time with the doctor we have instituted a policy to prevent late arrivals and missed appointments. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Appointment confirmations. You will receive a text confirmation sent to your cell phone two days in advance of your appointment date. If you do not respond to the text confirmation, then we will also give you a confirmation call on the day before your appointment. If you do not answer the call, then a voicemail will be left asking you to confirm your appointment. <u>If you do not respond to our attempts to confirm your appointment, then your appointment will be canceled</u>. If you arrive at your appointment without confirmation, we will do our best to squeeze you into our schedule, but you may need to be rescheduled to a different date and time.

2. Late arrivals. Late arrivals may extend wait times for all of our patients. We will do our best to accommodate you if you arrive late. Nonetheless, If you arrive more than 15 minutes late to your appointment, you may be asked to reschedule your appointment to a different date and time.

3. No-shows (missed appointments) or same-day rescheduled appointments. We understand that unforeseen circumstances may prevent you from keeping a scheduled appointment in our office. In general, our office needs to be notified 24 hours in advance to reschedule or cancel an appointment. If you confirm your appointment and miss the appointment, then the following actions will be taken by our office:
<u>1st</u> occurrence: You will be reminded of our policy.
<u>2nd</u> occurrence: A <u>$25 balance</u> will need to be paid before making future appointments.
<u>3rd</u> occurrence: You may be <u>discharged</u> from our office.

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Thank you for reading and understanding our appointments policy. Please let us know if you have any questions or concerns!

I have read and understand the appointments policy and agree to abide by its guidelines.

Signature of patient or responsible party

_________________________ _________________________ ________

Patient Name Patient Signature Date

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Refraction Policy

Refraction is the portion of an eye exam where a glasses prescription is determined. We have created this refraction policy to help you better understand how prescriptions for glasses are handled by our office. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We do not participate in any vision insurance plans. In addition, Medicare does not cover refraction services. If you are a new patient to our office, and you are paying for your office visit as a "cash" patient, then a refraction will be included in your office visit cash fee.

2. Refraction options. We will give you the option of obtaining your refraction in our office for a $48 fee, or obtaining your refraction with a local optometrist.

3. Adjustments. If there is a need to re-evaluate a glasses prescription from our office, then it may be done (free of charge) within 90 days of the refraction. After this time frame, you may be subject to a second $48 refraction fee.

I have read and understand the payment policy and agree to abide by its guidelines

Signature of patient or responsible party

_________________________ _________________________ ________

Patient Name Patient Signature Date