EAST BAY EYE CENTERS

Excellence in Eye Care

Todd D. Severin, M.D.
Diplomate American Board
of Ophthalmology
Glaucoma, Anterior Segment Surgery

Sanford L. Severin, M.D., F.I.C.S.
Diplomate American Board
of Ophthalmology
Medical Ophthalmology

Aimée R. P. Edell, M.D.
Diplomate American Board
of Ophthalmology
Corneal Surgery and Disorders of
the Anterior Segment

Rahul Raghu, M.D., MBA
Diplomate American Board
of Ophthalmology
Glaucoma, Anterior Segment Surgery

Vahid Feiz, M.D.
Diplomate American Board
of Ophthalmology
Cornea and Refractive Surgery

Edward A. Laubach, O.D.
Contact Lens Services

Neda Akhondan, O.D.
Glaucoma Certified

5801 Norris Canyon Road Ste. 200
San Ramon, CA 94583-5406
T: 925 830-8823 F: 925 866-6610

8440 Brentwood Blvd., Ste. D
Brentwood, CA 94513
T: 925 701-8824 F: 925 866-6610

www.severinmd.com
eastbayeye@severinmd.com

Dear Patient:

Attached are the necessary forms that need to be filled out for your appointment. Please allow to be here for 1.5 to 2 hours (Cataract Evaluations, 3 to 3.5 hours)

PLEASE BRING COMPLETED FORMS WITH YOU FOR YOUR APPOINTMENT

Please fill out the forms as indicated:

1) **Registration: Complete all information sign and date.**

2) **Review of Systems: Check either yes or no for each item.**

3) **Financial Policy: Please read both pages and initial.**

4) **NOTICE OF PRIVACY PRACTICES (HIPAA).** (This form is yours to keep)

5) **Map: Directions to reach the office.** (This form is yours to keep)

24 HOUR CANCELLATION NOTICE REQUIRED
OR
$50.00 CANCELLATION FEE WILL BE CHARGED

FINANCIAL POLICY OF *EAST BAY EYE CENTER MEDICAL CORPORATION*

PATIENTS WITHOUT INSURANCE

Self-Pay

Our fees cannot always be determined in advance since they depend on services rendered so we are unable to give you a quote prior to being seen. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

PATIENTS WITH INSURANCE

We require you to show your current insurance cards at each visit.

Although we bill your insurance company or Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan or Medical Group, we will contact you for assistance. Should your health plan or Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

MEDICARE

We will bill Medicare, secondary and tertiary health plans for you. You must, however, supply us with the most up-to-date and correct information at the time of your visit. You will be responsible for your deductible and co-pays. If you do not have a supplemental insurance, or if you do not bring your card, you will be required to pay the 20% that Medicare does not cover at the time of your visit.

Qualified Medicare Beneficiaries (QMB's)

If you are a patient with Medicare QMB with Medi-Cal, CCHP, with or without a secondary insurance, we will see you with no out of pocket expenses charged to you for any Medicare covered service. *Make sure we are aware of your QMB Status.* Vision Exams (Refractions) are not a Medicare covered benefit and you will be expected to pay at the time of service.

PRIVATE INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account. If you have a co-pay or deductible, plan to pay it at the time of your visit.

HMO/PPO

CO-PAYMENT AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT. YOU MUST HAVE A CURRENT AUTHORIZATION/REFERRAL AT THE TIME OF YOUR VISIT.

Medicare/Medicaid, State Medi-Cal or County CCHP

We are not Medicaid/Medi-Cal providers. ***If you agree to be seen, you will be financially responsible for all unpaid Medicare allowed amounts and all non-covered charges.***

Vision Exams for Glasses, including refractions, are not covered by Medicare.

_____

Initials

LATE FEES

There will be an additional 10% charged for unpaid balances after 60 days and an additional 15% after 90 days. After 120 days the balance will go to collections. These charges are enforced after payments are received from your insurance.

MISSED APPOINTMENTS

I understand that there will be a minimum $50.00 charge for any missed office appointments without a 24-hour notice. ($100.00-$200.00 fee for multiple appointments scheduled in the same visit, i.e. testing with your doctor visit, multiple family members, etc.) *If you arrive 15 minutes or later, you may need to be rescheduled.*

SURGERY CANCELLATION FEES

There is a $300.00 cancellation fee if you need to cancel or reschedule your surgery. This fee is waived if it is cancelled by your physician for medical reasons. Scheduling surgery is extremely time consuming, therefore **we ask that you are sure of your dates prior to committing to them**.

FORMS AND MISCELLANEOUS FEES

Due to the large number of form requests received by our office we have been forced to charge for their completion. An example of charges is listed below.

FORMS	FEE
Private or Miscellaneous forms, (including DMV forms).....	$10.00
Specialty letters per patient request (Grievance, appeals, or letters of medical necessity)	$25.00
Copies of testing…….Black & White $5.00…..Color…..$25.00	
PRIOR AUTHORIZATION for denial of prescription medications……	$15.00
Returned checks for non-sufficient funds, closed accounts, etc……	$25.00

Fees for copies of your records are found in the HIPAA Policy. This includes sending copies to other doctors

RE-BILLING FEES

If we are not provided with the most current insurance information and we have to re-bill, there will be an additional $20.00 charge.

We accept cash, checks and most major credit cards

Thank you for understanding our financial policy.

Please let us know If you have any questions or concerns.

BY SIGNING AND CHECKING THE ACKNOWLEDGEMENT BOX ON THE REGISTRATION FORM, YOU ARE ACKNOWLEDGING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE INFORMATION

_____ _____

Initials **Date**

Directions to our facilities

Coming from the NORTH:
(Walnut Creek, San Francisco)

Go South on 680 to Crow Canyon Boulevard Exit by turning left and going over the freeway. Continue on Crow Canyon to Alcosta Boulevard. Turn right and go one block to Norris Canyon Road. Turn Left. Go up the drive and turn at the first right. At the next left you will see the sign for the Physicians' Office Buildings, turn. Drive to the back of lot, turn left, 5801 is on your right, Suite 200

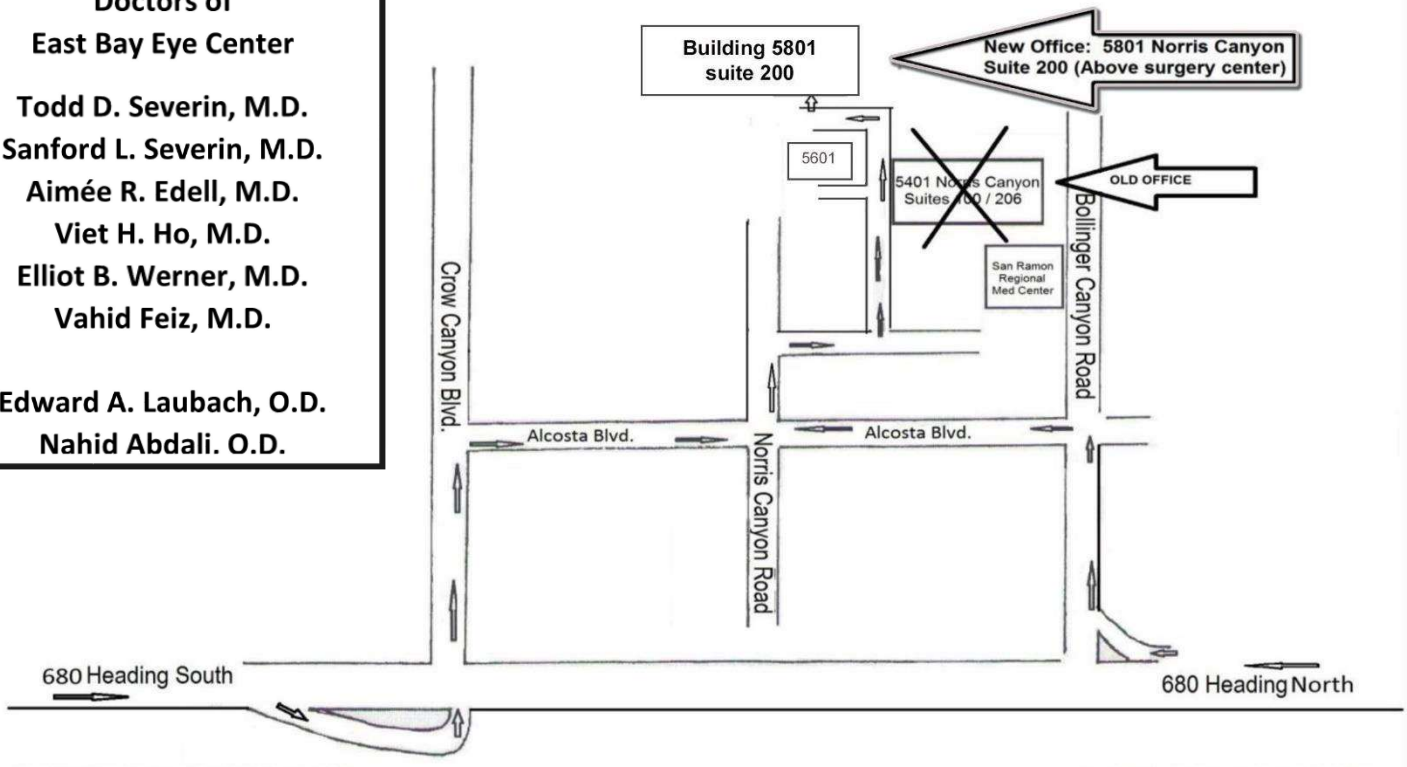
Coming from the SOUTH:
(Livermore, Dublin, Hayward)

Go North on 680 to Bollinger Canyon Exit. Turn East (right) and proceed to Alcosta Boulevard. Turn left on Alcosta and continue to Norris Canyon Road. Turn right. Make another right at the sign for the Physicians' Office Buildings, turn left. Drive to the back of the lot, turn left, 5801 is on your right, Suite 200.

Doctors of
East Bay Eye Center

Todd D. Severin, M.D.
Sanford L. Severin, M.D.
Aimée R. Edell, M.D.
Viet H. Ho, M.D.
Elliot B. Werner, M.D.
Vahid Feiz, M.D.

Edward A. Laubach, O.D.
Nahid Abdali. O.D.



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14,2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Tammy Carson. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need-to-know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, but only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care in case of any emergency, involving your care, your location, your general condition, or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to our medical records staff, outside health or management reviewers, and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR RIGHT TO PRIVACY AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *.25 cents* for each page and the staff time charged will be $ *16.00* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures, therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we have made regarding your access to your health information, you can submit a complaint to us in writing. Please request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: **East Bay Eye Center Medical Corporation**

Privacy Officer: **Tammy Carson COA, OCS, OSC**

Telephone: (**925) 830-8823** Fax: (**925) 866-6610**

E-Mail: **tcarson@severinmd.com**

Address: **5801 Norris Canyon Road**
Suite 200
San Ramon, CA 94583-5406

EAST BAY EYE CENTERS MEDICAL CORPORATION PATIENT REGISTRATION

PATIENT NAME:_____ _____-_____-_____

(Mr/Mrs/Ms/Miss/Dr LAST FIRST MI SOCIAL SECURITY #

AGE:_____ DATE OF BIRTH:_____/_____/_____ GENDER: M / F

PREFERRED LANGUAGE_____ RACE:_____ETHNICITY:_____

ADDRESS:_____

STREET CITY STATE ZIP

HOME PHONE: (____)_____CELL PHONE: (_____)_____ WORK PHONE: (_____)_____

EMAIL: _____(by giving my email address, I understand Protected Health Information may be sent through email and agree to email communication)

EMPLOYER:_____ OCCUPATION:_____ MAY WE CONTACT YOU AT WORK? Y / N

EMERGENCY CONTACT PERSON:_____ PHONE: (____)_____

IN CASE OF MINOR/DISABLED PERSON PLEASE LIST NAME OF RESPONSIBLE PARTY: PHONE:_____

NAME:_____RELATIONSHIP:_____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **East Bay Eye Center** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notices of Privacy Practices. Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity Relationship

_____

_____

_____

PRIMARY INSURANCE:_____HMO GRP NAME (IF APP):_____

SUBSCRIBER NAME:_____ SUBSCRIBER'S ID# and/or SS#:_____

SUBSCRIBER DATE OF BIRTH:____/____/____

SECONDARY INSURANCE:_____HMO GRP NAME (IF APP):_____

SUBSCRIBER NAME:_____ SUBSCRIBER'S ID# and/or SS#:_____

SUBSCRIBER'S DATE OF BIRTH:____/____/____

☐ **By checking this box, I acknowledge that I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.**

☐ **By checking this box, I acknowledge that I have been provided a copy of the Financial Policy to keep. I understand, that I, the patient or the patient's representative, have read, understand and agree to the information in the policy. I understand that I, the patient or patent's representative, am/is responsible for payment of all charges for services rendered.**

☐ **By checking this box, I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to East Bay Eye Center Medical Corporation.**

I, THE UNDERSIGNED, HAVE READ, UNDERSTAND, AND AGREE TO THE INFORMATION I HAVE BEEN GIVEN

_____ _____

Patient or Responsible Party Signature Date

REFERRING PROVIDER: _____PHONE: (___) _____

PRIMARY CARE PROVIDER: _____PHONE: (___) _____

OPTOMETRIST/VISION CENTER: _____PHONE: (___) _____

PERSONAL EYE HISTORY (Please check all that apply)

- ☐ Cataracts
- ☐ Retinal Detachment/Tears
- ☐ Glaucoma
- ☐ Floaters
- ☐ Diabetic Retinopathy
- ☐ Dry/Watery Eyes
- ☐ Lazy Eye
- ☐ Crossed Eyes/Strabismus
- ☐ Droopy Lids
- ☐ Macular Degeneration
- ☐ Refractive Vision Correction
- ☐ Retinal Hemorrhages/Bleeding
- ☐ Retinal Lasers or Surgeries
- ☐ Ocular Migraines
- ☐ Traumatic Injuries/Accidents

Please explain any of the above as well as other history or conditions: _____

_____

List all Eye Drop Medications:_____

_____

PERSONAL MEDICAL HISTORY (Please complete Review of Systems form)

Any other illness not listed (Please Specify):_____

Please list all prescription medications and / or all vitamins and over the counter remedies currently taking. (Please include blood thinners like aspirin and anti-inflammatory agents**) _____**

_____

_____

_____

Allergies to Medications: Yes_____ No_____ Please List_____

Do you have a Pacemaker/Cardiac Defibrillator? (Please state which) _____

List all surgical procedures/dates:_____

_____

_____

FAMILY HISTORY (Check all that apply and what family member)

- ☐ Cataracts _____
- ☐ Glaucoma_____
- ☐ Thyroid_____
- ☐ Kidney Disease_____
- ☐ Asthma_____
- ☐ High Blood Pressure_____
- ☐ Liver Disease_____
- ☐ Heart Disease_____
- ☐ Stroke_____
- ☐ Cancer_____
- ☐ Retinal Detachment/Tears_____
- ☐ Diabetic Retinopathy_____
- ☐ Macular Degeneration_____
- ☐ Diabetes Type I___ Type II___/_____

SOCIAL HISTORY - Single_____ Married _____ Divorced_____ Widowed_____ Separated_____

Do you Drink Alcohol? Yes___ No___ How Often? _____ Do you use recreational drugs? Yes___ No___ Specify_____

Do you Smoke? Yes___ No___ Packs/Day_____ Have you had any weight changes? No___ Gain___ Loss___

Patient's Signature_____Date_____

Patient's Name:_____Date of Birth:_____

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas? Please mark Yes (Y) or No (N) for each one.

Cardiovascular	Y	N
Chest Pain		
Irregular Heartbeat		
Shortness of breath		
Stroke		

HEENT	Y	N
Dizziness		
Loss of Hearing/Deaf		
Hoarseness		
Ringing in Ears		
Sore Throat		
Recent Viral Infection		
Dryness of Mouth		

Musculoskeletal	Y	N
Back Pain		
Joint Pain		
Muscle or Neck Pain		
Stiffness		
Swelling		
Arthritis		

Respiratory	Y	N
Cough		
Trouble Breathing		
Wheezing		
Chronic Bronchitis		
Chronic Emphysema/COPD		
Asthma		
Sleep Apnea		

Blood Pressure Control	Y	N
Borderline BP control		
Good BP Control		
Poor BP Control		
Unknown BP Control		

Constitutional	Y	N
Fatigue/Tire Easily		
Fever		
Night Sweats		
Weakness		
Weight Loss		

Blood-Hematologic	Y	N
Bleeding Disorder		
Bruising		
Tender Nodes		
Anemia		
Hepatitis _____		

Neurological	Y	N
Balance Problems		
Headaches		
Numbness		
Tingling		
Seizures		
Multiple Sclerosis		

Integumentary (Skin)	Y	N
Hair Loss		
Rashes/Facial Acne		
Skin Lesions		
Rosacea		
Shingles		
Herpes		

Diabetes	Y	N
Borderline DM Control		
Good Dm Control		
Poor DM Control		
Unknown DM Control		
Diabetes Type I/Type II		

Genitourinary	Y	N
Genital Discharge		
Genital Sores		
Painful Urination		
Urgency		

Metabolic	Y	N
Cold Intolerance		
Excessive Hunger		
Frequent Urination		
Heat Intolerance		
Grave's Disease		
Hashimoto's Disease		
Thyroid Hyper/Hypo _		

Psychiatric	Y	N
Anxiety		
Depression		
Insomnia		
Irritability		
Nervousness		

Allergic-Immunologic	Y	N
Chronic Runny Nose		
Hives		
Itching		
Hay Fever Symptoms		
Skin or Respiratory		
Lupus		
Rheumatoid Arthritis		

Pregnancy	Y	N
First Trimester		
Second Trimester		
Third Trimester		

Eyes	Y	N
Burning		
Crossed Eyes		
Distorted Vision		
Double Vision		
Dryness of Eyes		

Eyes (Continued)	Y	N
Excess Tearing		
Eye Pain or Soreness		
Flashing Lights		
Floating Objects		

Eyes (Continued)	Y	N
Glare/Light Sensitive		
Itching		
Lazy Eye (Amblyopia)		
Loss of Vision		
Redness		

Eyes (Continued)
Past Eye Surgery
1.
2.
3.
4.
5.

Past Medical Surgery
Type of Surgery
1.
2.
3.
4.
5.

REVIEWED / PERFORMED / UPDATED_____M.D. / O.D. DATE: _____

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Welcome to the East Bay Eye Centers
MEDICAL CORPORATION

- **Diagnosis and treatment of glaucoma**
- **Cataract surgery with the latest lens implants**
- **Refractive Surgery**
- **Functional, cosmetic, and reconstructive surgery**
- **Diagnosis and management of medical vision problems**
- **Comprehensive eye examinations**
- **Treatment for dry eyes**
- **Botox and facial rejuvenation**

Thanks to the marvels of the internet and e-mail, we are able to help you save time at your next appointment with East Bay Eye Centers. Enclosed are the necessary forms for your upcoming appointment.

We advocate regular medical examinations to safeguard the health of your eyes. New diagnostic and treatment techniques allow us to detect abnormalities early so that successful treatment can be initiated.

Please bring your eye wear and a list of all your current eye drops and oral medications, including over-the-counter medications and supplements.

Hours & Scheduling:

The doctors of the East Bay Eye Centers see patients, by appointment only, Monday through Friday. If you are not able to keep your appointment, **please give us 24 hour notice**. **We bill $50.00-$200.00 for appointments that are missed without notice**. *If you are running late, please call the office as soon as possible so that we may attempt to accommodate your needs.*

What to Expect:

The length of your appointment can vary based on the severity and complexity of your eye condition. As we are a referral practice, frequent and unpredictable emergencies are sent to us for our immediate attention, and our appointment schedule, at times, may be delayed. Depending on what you're being examined for, both of your eyes may be dilated and this can affect your ability to drive. It is recommended that you arrange for transportation to and from our office.