PATIENT INFORMATION

YOUNG H. CHOI, M.D.

Innovative Leader in Cataract Surgery

Welcome to our office. Please complete this form. PLEASE PRINT.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Age _____ Male/Female _____

Social Security # _____ Family Physician _____

Occupation _____ Employer _____

Person to Notify in Emergency _____ Phone _____

Name of Referring Doctor or Patient _____

Email address of patient or family member required _____

RELEASE OF MEDICAL RECORDS

I authorize InVision Ophthalmology to request or release any information from or to any physician, medical institution, or insurance company as necessary for my medical care or purposes of filing insurance claims.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that regardless of my insurance status, I am ultimately responsible for any medical or surgical services rendered to my family or me. I am responsible for all non-covered services. I assign payment to and authorize payment directly to InVision Ophthalmology for all medical and surgical benefits. In the event or default, I agree to pay all costs of collection including reasonable attorney's fees.

MEDICARE PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

_____ _____

Signature of Patient or Responsible Party Date

INSURANCE SIGNATURE STATEMENT

YOUNG H. CHOI, M.D.

Innovative Leader in Cataract Surgery

Patient Name _____ Medicare Number _____

MEDICARE I request that payment of authorized Medicare benefits be made on my behalf to InVision Ophthalmology for services furnished by InVision Ophthalmology. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. InVision Ophthalmology accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MEDIGAP I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Invision Ophthalmology, if possible or otherwise to me.

RELEASE OF INFORMATION InVision Ophthalmology may disclose all or any art of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to InVision Ophthalmology for reimbursement for services rendered, and (2) any health care provider for continued patient care. InVision Ophthalmology may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place or the original.

OTHER INSURANCE I understand that InVision Ophthalmology maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. I understand that InVision Ophthalmology has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by InVision Ophthalmology if I belong to a plan that does not appear on the above-mentioned list.

NONCOVERED SERVICES I understand that InVision Ophthalmology contracts with health care service plans (i.e., HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of noncovered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with InVision Ophthalmology to obtain necessary health care service plan authorizations. *All non-covered fees will be collected upon check-out.*

FINANCIAL AGREEMENT I agree that in return for the services provided to the patient by InVision Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to InVision Ophthalmology for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to InVision Ophthalmology. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to InVision Ophthalmology. *However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.*

_____ _____

Signature of Patient or Authorized Party Date

Advance Beneficiary Notice (ABN) –

NOTE: You need to make a choice about receiving these health care items or services. We Expect that Insurance may not pay for the items(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when Insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Insurance may not pay for some of the following items or services:

Items or Services:	**Reasons Insurance may not pay**
Contact Lens Punctal Plugs Refraction Routine Examination Some Surgeries – such as Intacs Some Testing – such as OCT, Pentacam, Photographs	Copayment Deductible Not covered

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. Ask us to explain, if you do not understand why Insurance may not pay. Ask us how much these items or services will cost you (Estimated Cost: $ 15 – 7,500), in case you have to pay for them yourself or through other insurance.

Please Choose ONE Option. Check ONE Box. Then Sign & Date Your Choice.
If you do not select Option 1 or Option 2 then Option 1 will be assumed as your choice.

☐ **Option 1. YES I understand that it will be my responsibility to pay for any items or services**
I have read and understand the above information. I accept full financial responsibility for the cost of any uncovered services if provided, and understand payment is due at time of service. I understand that any co-payment, coinsurance or deductible I may have is separate from and not included in these fees. I understand that Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Insurance is making its decision. If Insurance does pay, you will refund to me any payments I made to you that are due to me. If Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Insurance's decision. I also understand that an additional 40% collections fee will be charged to any account that is turned over to the collections agency for nonpayment of services.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Insurance and that I will not be able to appeal your opinion that Insurance will not Pay.

_____ _____
Patient's Name Signature of patient or person acting on patient's behalf

_____ _____
Insurance Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Insurance, your health information on this form may be shared with Insurance. Your health information which Insurance sees will be kept confidential by Insurance.

OMB Approval No. 0938-0566 Form No. CMS –R-131-G (June 2001)

Patient Name _____

Patient Date of Birth _____

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ADVANCED CARE DIRECTIVE QUESTIONNAIRE

(for patients 65 or older)

Have you had a pneumonia vaccine? □ Yes □ No

Do you have a health care proxy (*representative*) in the event you are unable to make your own medical decisions? □ Yes □ No

(If YES, please give the following):

Name of representative _____

Phone number of representative _____

Do you have a living will? □ Yes □ No

Which statement(s) best reflects your wishes on advanced care recommendations?

□ Do Not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

□ Do No Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated defibrillator to restart my heart, even if it is necessary to save my life.

□ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation to be made.

Patient Signature _____

EYE AND MEDICAL HISTORY

YOUNG H. CHOI, M.D.

Innovative Leader in Cataract Surgery

Patient Name _____ Date _____

Family Physician _____ Birthdate _____

EYE HISTORY

Known Eye Disease _____

Current Eye Medications _____

Previous Eye Surgery _____

Previous Eye Laser _____

Previous Eye Injury _____

MEDICAL HISTORY

Diabetes	yes □ no □	Hypertension	yes □ no □
Heart Disease	yes □ no □	Lung Disease	yes □ no □
Stroke	yes □ no □	Cancer _____	yes □ no □

Other _____

Current Medications _____

_____

Previous Surgery _____

_____

Medication Allergy _____

REVIEW OF SYSTEMS

Do you currently have any of the following:	yes	no	if yes, explain
Chronic fever, unexpected weight gain or loss	□	□	_____
Ear/nose/throat problems (hearing loss, sinus, sore throat)	□	□	_____
Heart Problems (chest pain, irregular heart beat)	□	□	_____
Respiratory Problems (shortness of breath, wheezing, coughing)	□	□	_____
Gastrointestinal Problems (abdominal pain, diarrhea, vomiting)	□	□	_____
Urinary Problems (pain or discomfort, blood in urine)	□	□	_____
Skin Problems (rashes, excessive dryness)	□	□	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	□	□	_____
Neurologic Problems (numbness, weakness, headaches, paralysis)	□	□	_____
Psychiatric Problems (depression, anxiety)	□	□	_____
History of abdominal bleeding	□	□	_____

SOCIAL HISTORY

Tobacco Use	yes □ no □	Alcohol Use	yes □ no □
Married	yes □ no □	Occupation _____	

FAMILY HISTORY

Glaucoma	yes □ no □	Blindness	yes □ no □
Diabetes	yes □ no □	Cancer _____	yes □ no □
Heart Disease	yes □ no □	Hypertension	yes □ no □
Abnormal bleeding	yes □ no □		

_____

Physician Signature

Home Medication List

Patient Name _____

Date of Birth _____

Please bring this COMPLETED form to the office of InVision Ophthalmology/Dr. Choi's office on the day of your visit. List ALL medications you currently take (prescription, over-the-counter, vitamins, herbal supplements, medication pumps, patches, inhalers, drops, sprays or ointments)

Allergy/Intolerance

Medication	**Dose and Frequency**

Above medications should be continued at home, in addition to the prescription on the discharge sheet, unless specified to discontinue by your MD.

ASPIRIN, BLOOD THINNERS, ANTI-INFLAMMATORY USED WITHIN THE LAST 10 DAYS? YES NO (please circle one)

Name of Medication _____ Date of last dose taken _____

List verified on admission by _____ Date and Time _____

DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

For all new prescriptions, consult with your Pharmacist regarding side effects and drug interactions of medications. Please refer to your Primary Care Provider or prescribing physician if you have any questions about resuming specific medications. ***Eye Surgery patients should refer to instruction sheet for use of eye drops after surgery.***

Patient/Pt. Representative Signature _____ Date/Time _____

Nurse Signature _____ Date/Time _____