



**Focal Point Vision**  
FOCALPOINTVISION.COM

## FINANCIAL POLICY

Thank You for choosing Focal Point Vision as your healthcare provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at anytime.

**INSURANCE POLICY:** Your insurance is between you and the insurance company. Snip & Ference DBA Focal Point Vision's relationship is with you and not the insurance company. On the same note, we extend a courtesy to our patients and file your claims for you. However, all charges are your responsibility from the date services are provided. As with the case of all contracts, you the insured are expected to know your policy and its regulations as agreed upon by you and your insurance company at the time of enrollment. This will include referrals, second opinions or prior authorization. Our experienced staff will gladly assist you with obtaining any precertification or prior authorization as needed. However, in the event of failure to provide accurate up to date insurance information resulting in a denial and non-payment for services rendered, payment will be the responsibility of the patient or the insured. Additionally, we cannot guarantee that the information given to us by your carrier is correct. Our involvement will be limited to supplying factual information to facilitate claim processing. Out of pocket expenses such as deductibles, coinsurance and copayments are your responsibility to be paid at the time of service as stated in your contract with the insurance company.

*In the event that the your insurance company does not cover certain tests like Scanning Computerized Ophthalmic Diagnostic Imaging (OCT), Corneal Topography or Visual Fields that our physicians would deem medically necessary in your care, you would be financially responsible for the cost of these tests.*

**SELF PAY:** Payment is required to be paid at the time of service unless prior arrangements have been made with our billing department. Focal Point Vision gladly accepts cash, checks, Visa and MasterCard. There is a \$25.00 returned check service charge.

**REFERRALS:** If you have an insurance that requires a referral. *It is your responsibility to obtain the referral from your primary care physician before your appointment.* Otherwise, the visit will not be covered by your insurance and you will be responsible for the payment. Please notify us if your insurance requires a pre-authorization for the office or outpatient procedures.

**REFRACTIONS:** Medicare and other health insurers will NOT pay for the glasses prescription. If you choose to have our doctor perform a refraction and provide you with an eyeglass prescription you must accept full financial responsibility for the cost of this service, the refraction fee is \$50.00. The fee will be collected at the time of services and rendered.

*Please note: All appointment cancellations and reschedules must be made at least 24 hours in advance. If you don't show to your appointment a charge of \$25.00 will be added to your account.*

I have read and fully understand and acknowledge the financial policy of Focal Point Vision. I acknowledge and agree to pay for any services and tests that are not covered by my insurance plan. Again, thank you for choosing Focal Point Vision as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

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Patient Signature

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Date



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## OCULAR AND MEDICAL HISTORY

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### PLEASE CHECK IF YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING:

Arthritis/Joint problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric problems/Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease/Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems/Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes Simplex	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke or Neurological problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bronchitis/COPD/ Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Headaches/ Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain/Discomfort	Yes <input type="checkbox"/> No <input type="checkbox"/>	Excessive bleeding <small>with surgery</small>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice/Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Unexplained Weight loss/gain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dialysis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney/Renal Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Insulin dependent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes Type 1 <input type="checkbox"/> 2 <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gastritis/Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prostrate Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (explain): _____	

### PAST OCULAR HISTORY *Please check all that apply*

Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dry Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Astigmatism	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Detachment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Myopia (near-sighted)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetic Retinopathy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hyperopia (far-sighted)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Keratoconus	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Infections	Yes <input type="checkbox"/> No <input type="checkbox"/>	Amblyopia (lazy eye)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Floater	Yes <input type="checkbox"/> No <input type="checkbox"/>	Corneal Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Injuries	Yes <input type="checkbox"/> No <input type="checkbox"/>

### OCULAR SURGERIES/PROCEDURES *Please check all that apply*

Cataract Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Laser Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lasik/PRK/RK	Yes <input type="checkbox"/> No <input type="checkbox"/>
Corneal Transplant	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (explain): _____	

### FAMILY HISTORY *Please check all that apply*

Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fuch's Dystrophy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Detachment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Corneal Transplant	Yes <input type="checkbox"/> No <input type="checkbox"/>

### SOCIAL HISTORY *Please check all that apply*

Alcohol Use	Yes <input type="checkbox"/> No <input type="checkbox"/>	Able to read English	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drives Motor Vehicle	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do You Smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/> .....How often? _____				
Have you ever smoked?	Yes <input type="checkbox"/> No <input type="checkbox"/> .....When did you quit? _____				

Form completed by: \_\_\_\_\_

Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_





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## LIFESTYLE VISION QUESTIONNAIRE

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your exam, this information will assist us in recommending the best option for your eyes and your personal lifestyle.

### Do you wear glasses now?

Yes  No

### If yes, how frequently?

All the time       Sometimes       Only for distance       Only for reading       Only for the computer

### If yes, how do you feel about wearing glasses?

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If it were possible to go without glasses most of the time, would you like that?      Yes  No

### What type of visual outcome would you like after cataract surgery? (Check all that apply)

Reduce need for glasses       Reduces my prescription  
 See better than I did before surgery       I didn't realize there were options

### Check the following activities you do on a regular basis and underline the activities you would like to do without glasses, if possible.

Read newspapers/books       Play tennis       Golf  
 Hunt or fish       Use call phone       Read medicine bottles  
 Paint/draw       Watch movies in theatre       Needlepoint/sew  
 Watch spectator sports       Photography       Crossword puzzles  
 Cook       Participate in water sports       Visit/care for grandkids  
 Drive in the daytime       Drive in the nighttime       Use the computer  
 Other (please list )

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### How important is it for you to read or use the computer without glasses?

Very Important       Important       Not Important

### Please place an "X" on the following scale to describe your personality as best you can:

Easy going ... .. Perfectionist



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## PATIENT INFORMATION

### THE PATIENT

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State and zip: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Marital Status:  Married  Single  Divorced  Widow  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino  
**Race:**  African American  American Indian or Alaskan Native  Asian  Caucasian  
 Hispanic or Latino  Native Hawaiian or Other Pacific Islander  Other (please list): \_\_\_\_\_

**Preferred Language:**  English  Spanish  Other: \_\_\_\_\_

**Preference of appointment reminder:**  Phone  Text  Email: \_\_\_\_\_

**How did you hear about us?**  Internet  Friend  Other: \_\_\_\_\_  Dr. \_\_\_\_\_

#### Primary Insurance:

ID #: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Ph: \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Relation to Insured:  
 Self  Spouse  Child  Other: \_\_\_\_\_

#### Secondary Insurance:

ID #: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Ph: \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Relation to Insured:  
 Self  Spouse  Child  Other: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Referring Eye Care Provider:** \_\_\_\_\_ Phone: \_\_\_\_\_

**THE RESPONSIBLE PARTY** Are you, the patient, and the responsible party for this account? Yes  No

#### If someone other than the patient is responsible for this account please provide their information.

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State and zip: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email address: \_\_\_\_\_

I hereby authorize my insurance company to pay directly to Focal Point Vision Correction, all benefits otherwise payable to me under the provisions of my policy. I hereby authorize the necessary medical information to be released to the insurance company for processing this claim and to be released to physicians or optometrists in connection with the continuity of care of patient. Photostat copies of this authorization will be considered as valid as the original.

Form completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_



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## MEDICAL NECESSITY

Patient name: \_\_\_\_\_ Surgeon: \_\_\_\_\_ OD/OS Date: \_\_\_\_\_

### DO YOU HAVE DIFFICULTY (EVEN WITH GLASSES) WITH THE FOLLOWING?

#### Reading small print such as labels on medicine bottles, a telephone book or food labels?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Reading a newspaper or book?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Seeing steps, stairs or curbs?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Reading traffic signs, street signs or store signs?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Doing fine handwork like sewing, knitting, crocheting or carpentry?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Writing checks or filling out forms?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Playing games such as bingo, dominos, card games or mahjong?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity

#### Watching television?

Yes  No  Not Applicable

If yes, how much difficulty do you currently have?

A little  A moderate amount  A great deal  Unable to do the activity



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Notice to patient:** We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details): \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



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## ELECTRONIC PRESCRIBING CONSENT

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Patient name

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DOB

The providers at Focal Point Vision use an electronic medical record system (EMR) that permits our providers to prescribe medications electronically. The capability is known as **E-Prescribing** and is defined as a physician's ability to electronically send an accurate and understandable prescription directly to the pharmacy from the point of care. Congress has determined that the ability to send prescriptions electronically is an important element in improving the quality of patient care. This process helps reduce medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program.

These include:

### **Formulary and Benefit Transactions**

Gives the prescriber information about which drugs are covered by the drug benefit plan.

### **Medication History Transactions**

Provides the physician with information about medications that the patient is already taking to minimize the number of adverse drug events.

### **Fill Status Notification**

Allows the prescriber to receive an electronic notice from the pharmacy notifying them if the patient's prescription has been picked up, or partially filled.

By signing this consent form you are agreeing that Focal Point Vision can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Focal Point Vision to enroll me in the E-Prescribing Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Accept       Decline

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Patient name

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DOB

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Signature of patient

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Date





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## CATARACT NEW PATIENT PACKET

Thank you for trusting Focal Point Vision with your eye care needs. We want you to be well-informed about your cataract surgery options before coming to your appointment and encourage you to visit our website at [www.focalpointvision.com](http://www.focalpointvision.com).

### WHAT IS A CATARACT?

All of us are born with a flexible, clear lens in our eye called the "crystalline lens." As this lens becomes cloudy and less flexible, we call it a cataract. This lens is responsible for cloudy distance vision, occasional poor near vision, and problems with contrast and glare. During cataract surgery your surgeon will be replacing the natural cloudy lens with a clear artificial lens implant.

### WHAT IS ASTIGMATISM?

It is a highly common condition that happens when the eye is shaped like a football instead of like a basketball. This can cause blurriness and double vision, as well as affect distance vision.

At Focal Point Vision our surgeons offer patients various options for their cataract surgery. For that reason, we invest and train our staff on different types of technologies that remove the cataract, and different types of implants that correct distance vision, astigmatism and improve near vision.

Cataract surgery has made amazing advancements. Traditionally, we have used ultrasound energy to remove cataracts. Today almost 50% of our cataract surgeries use LENSAR femtosecond laser new laser to make incisions, correct astigmatism, and disassemble the cataract. This new technology allows more precise surgery and in most cases improved recovery.

**FOCAL POINT VISION IS 1 OF 5 SITES IN THE US TO CURRENTLY OFFER PATIENTS THE EXCLUSIVE RXSIGHT LAL (LIGHT ADJUSTABLE LENS), THE FIRST CUSTOMIZABLE INTRAOCULAR LENS.**

We are the only practice in central and south Texas to offer to this technology to cataract patients. It allows our surgeons to customize and change your implant power after surgery.



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Below you will see your surgical options. It is important to remember that Medicare and commercial insurances typically cover the costs of cataract surgery because it is a medically necessary procedure. However, if you choose to undergo surgery with the LENSAR femtosecond laser and/or a specialized implant (or IOL), Medicare and commercial insurances consider these "non-covered services". This means it would be an out-of-pocket expense. Lastly, cataract surgery falls under medical insurance, not a vision plan or vision insurance. Vision insurances and vision plans are used to cover exams for glasses and contacts. Financing may be available. Please contact our business office to review your financial options.

### **BASIC CATARACT SURGERY**

Basic cataract surgery is traditional cataract surgery designed for individuals who want to improved distance vision. Expectation for this package patient will need aid of glass for any astigmatism they may have and glasses for near vision.

### **CUSTOM ASTIGMATISM PACKAGE 1**

This is a laser cataract procedure with the use of LENSAR (femtosecond laser) and a standard intraocular lens implant. This will correct lower amount of astigmatism. It is designed for individuals who want good distance vision and correct lower levels of astigmatism.

### **CUSTOM ASTIGMATISM PACKAGE 2**

This package is an advanced laser cataract procedure with the use of LENSAR (femtosecond laser) and a toric intraocular lens, which will correct higher amount of astigmatism. It is designed for individuals who want sharp distance vision with higher levels of astigmatism.

### **CUSTOM LIFESTYLE PACKAGE**

This is advanced laser cataract procedure with the use of LENSAR (femtosecond laser) and an advanced technology implant. Advanced implants will correct distance, astigmatism and improve near vision. It is designed for individuals who want the widest range of vision with improved near vision.

Our goal is to treat patients like family. We customize your treatment for your needs and lifestyle. Regardless of which option you and your doctor choose, you will get an excellent quality care. We look forward to meeting you at your consultation. (If you wear contact lenses please take them off a week before your appointment if possible)

Sincerely,  
Kenneth Maverick, MD and James Lehmann, MD

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San Antonio, TX 78229

Focal Point Vision Alamo Heights  
343 W. Sunset  
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