DOUGHERTY
LASER VISION

WELCOME TO DOUGHERTY LASER VISION

Who may we thank for referring you to Dougherty Laser Vision?

☐ **Friend/Patient:** ______________________

☐ **Optometrist/OD:** ______________________

☐ **Physician/MD:** ______________________

☐ **Organization:** ______________________

☐ **Event:** ______________________

☐ **Staff Member:** ______________________

☐ **Other:** ______________________

☐ **Advertising: (*please circle*)**

The Acorn, Westlake Magazine, YHC Magazine, Calabasas Style, Leisure Village, Movie Theater, Our Website, Internet, Mailer, Radio, T.V., VC Reporter, VC Star, Ventana, N Ranch Magazine, WLV Car Wash, VC Star Online, Zoc Doc, UCLA

Other advertising______________________

LAST NAME: ______________________ FIRST NAME: ______________________ M.I.:______

MR./MRS./MS./MISS (circle) GENDER: ☐ M ☐ F PREFERRED NAME: ______________________

D.O.B.: ______________ AGE: _____ S.S.N.: ________-_______-________ MARITAL STATUS: ____________

OCCUPATION: ______________________ HOBBIES: ______________________

PREFERRED LANGUAGE: ______________________ RACE: ______________________

ADDRESS: ______________________________________ APT./UNIT #: ____________

CITY: ______________________ STATE: ____________ ZIP: ____________

HOME PHONE: ______________________ CELL PHONE: ______________________

WORK PHONE: ______________________ EMPLOYER: ______________________

EMAIL ADDRESS:____

PRIMARY INSURANCE: ______________________ Is patient covered by additional insurance? Y N

NAMED INSURED: ______________________ S.S.N. if not self: ________-_______-________

EMERGENCY CONTACT: ______________________ PHONE: ______________________

PRIMARY CARE PHYSICIAN: ______________________OPTOMETRIST: ______________________

Are you interested in receiving information about any of our cosmetic services including:
BOTOX, Juvederm, Laser Hair Removal, Laser Skin Resurfacing? YES NO

Consent to treatment and financial agreement:
I hereby consent to and authorize treatment and medical services by Paul J. Dougherty, M.D. and staff and agree to pay all charges incurred. I hereby authorize my insurance company to pay Dr. Dougherty directly any medical, surgical, or major medical benefits due to me for services rendered. I authorize release of information requested by my insurance company regarding my treatment. It is the policy of this office that the parent who requests treatment for the child is responsible for all fees for services rendered.

Date: ______________ Signature: ______________________________________

Dougherty Laser Vision
MEDICAL HISTORY QUESTIONNAIRE

Last Name: ____________________ First Name: ______________________ MI: ______

Briefly state the reason for your visit: ____

____

Do you presently or have you had any problems in the following areas? If "YES," please explain.

	YES	NO	EXPLAIN
Eyes			
Redness	[ ]	[ ]	________
Gritty feeling, dryness, or tearing	[ ]	[ ]	________
Eye pain or soreness	[ ]	[ ]	________
Infection of eyes, eyelids, or sties	[ ]	[ ]	________
Glare/light sensitivity, or halos	[ ]	[ ]	________
Blurred vision or loss of vision	[ ]	[ ]	________
Double vision	[ ]	[ ]	________
Amblyopia (Lazy Eye)	[ ]	[ ]	________
Blepharitis	[ ]	[ ]	________
Cataract Surgery	[ ]	[ ]	________
Corneal Abrasion or Ulcer	[ ]	[ ]	________
Conjunctivitis (Pink Eye)	[ ]	[ ]	________
Dry Eye Syndrome	[ ]	[ ]	________
Trauma	[ ]	[ ]	________
Glaucoma	[ ]	[ ]	________
Herpes	[ ]	[ ]	________
Kerataconus	[ ]	[ ]	________
Retina (Tears, Holes, Detachment)	[ ]	[ ]	________
Surgery	[ ]	[ ]	________
Other (please list)	[ ]	[ ]	________
Ears, nose, mouth, throat (hearing, sinus)	[ ]	[ ]	________
Cardiovascular (heart, blood vessels)	[ ]	[ ]	________
Respiratory (asthma, lungs, breathing)	[ ]	[ ]	________
Gastrointestinal (stomach, intestines)	[ ]	[ ]	________
Genitourinary (genitals, kidney, bladder)	[ ]	[ ]	________
Musculoskeletal (muscles, joints)	[ ]	[ ]	________
Integument (skin, breast)	[ ]	[ ]	________
Neurologic (stroke, paralysis, numbness)	[ ]	[ ]	________
Psychiatric (depression, anxiety)	[ ]	[ ]	________
Endocrine (thyroid, hormones)	[ ]	[ ]	________
Hematologic (anemia, clotting problems)	[ ]	[ ]	________
Immunologic (hay fever, lupus, HIV)	[ ]	[ ]	________
Cancer (breast, lung, skin, colon, other)	[ ]	[ ]	________
General (weakness, fatigue, weight loss)	[ ]	[ ]	________

Please list any ALLERGIES to eye drops: ______________________________

____

Please list any eye drops currently using: ______________________________

____

____

Please list all of the medications that you are currently using (except eye drops): ____________

____

____

____

Please list all major illnesses (such as diabetes, hypertension, hypercholesterolemia, etc.): ______

____

____

____

Please list all major surgical procedures: ______________________________

____

____

____

Do you have any medication allergies? [ ] YES [ ] NO
If yes, please list all medication allergies: ______________________________

FAMILY HISTORY: Does anybody in your family have or have had any of the following?

Eyes	**YES**	**NO**	**EXPLAIN**
Blindness	[ ]	[ ]	____________
Cataract	[ ]	[ ]	____________
Glaucoma	[ ]	[ ]	____________
Macular Degeneration	[ ]	[ ]	____________
Retinal Detachment	[ ]	[ ]	____________
Medical			
Diabetes	[ ]	[ ]	____________
Arthritis, lupus, etc.	[ ]	[ ]	____________

SOCIAL HISTORY:

Eyes	**YES**	**NO**	**EXPLAIN**
Have you ever tried to wear contact lenses?	[ ]	[ ]	____________
Did you have any problems with contacts?	[ ]	[ ]	____________
Does your vision cause problem with…			
Driving?	[ ]	[ ]	____________
Reading?	[ ]	[ ]	____________
Sports/outdoor activities?	[ ]	[ ]	____________
General			
Do you drink alcohol?	[ ]	[ ]	How much per day? ________
Do you smoke?	[ ]	[ ]	How many cigarettes per day? ______
Do you drive?	[ ]	[ ]	____________

Patient's Signature: ______________________________ **Date**: ____________

Physician's Signature: ______________________________ **Date**: ____________
History Reviewed: [ ] No changes [ ] Additions as noted

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HEALTH PLAN ELIGIBILITY FORM

Patient Name ______________________ Date of Birth ____________

Subscriber's Name ______________________ Relation to patient ____________

Subscriber's Social Security ______________________ Subscriber's Date of Birth ____________

Primary Health Plan ______________________ PPO/HMO/MEDICARE/MEDI-CAL
Type of Plan (Please circle)

____/____/____
Effective date of coverage

Plan ID Number ____________

Secondary Health Plan ______________________ PPO/HMO/MEDICARE/MEDI-CAL
Type of Plan (Please circle)

____/____/____
Effective date of coverage

Plan ID Number ____________

I, the above named patient, hereby certify that I am eligible for medical coverage under the health plan and effective date listed above. I understand that if I am determined not to be eligible for the health care provided, I am liable for all charges for the services rendered. I agree that if I am not eligible, I (or the person financially responsible for me) will pay all charges in full within thirty (30) days of receiving notification.

Patient Signature ______________________ Date ____/____/____

Financially Responsible Party Signature ______________________ Date ____/____/____

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ADVANCE NOTICE OF DENIAL

A comprehensive medical eye examination should include a refraction for glasses.
The refraction determines what your lens correction is for your glasses and/or contacts.

Most insurance companies deem a refraction as not medically necessary and will not pay for this portion of your eye exam.

The cash fee for the refraction is $45.00

SIGNATURE: ______________________________

DATE: ______________

I DO NOT WISH TO HAVE A REFRACTION

SIGNATURE: ______________________________

DATE: ______________

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MEDICAL RELEASE AUTHORIZATION

MEDICARE PATIENTS ONLY

Medicare requires that we have you sign a release of information and authorization to pay Paul J. Dougherty, M.D. and/or his associates each year. Please complete this form so that we may bill Medicare and your contracted supplemental insurance for all examinations, treatments, in office procedures, and surgical services.

Patient name: ______________________________

Medicare number: ______________________________

If we are a contracted provider of your supplemental insurance company, we will bill them for you. If we are not contracted you may bill them yourself after you have received a Medicare Explanation of Benefits.

Supplemental insurance: ______________________________

I.D. number: ____________________ Group Number: ____________________

In some instances Medicare may be your secondary insurance coverage.

Are you or your spouse working? (please circle) YES NO

If yes, please specify. (please circle) Myself Spouse

Employer: ______________________________

Primary insurance company: ______________________________

I.D. number: ______________________________

I request that payment of authorized Medicare and contracted supplement benefits be made on my behalf to Paul J. Dougherty, MD and/or his associates for services furnished by the physician. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical information about me to release it to the health care financing administration or its agents. I also authorize information needed to determine these benefits may be released to determine these benefits or the benefits payable for related services.

Signature: ______________________________ Date: ____________________

DOUGHERTY LASER VISION

Acknowledgement of Receipt of Notice of Privacy Practices

Dougherty Laser Vision reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have received a copy of the Notice of the Privacy Practices for Dougherty Laser Vision.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient's Representative to Patient

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures:

Treatment. Your health information may be used by staff members or disclosed to other health care professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support day-to-day activities and management of Dougherty Laser Vision. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures Require your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of notice.

Dougherty Laser Vision Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending letter outlining your concerns to:

Dougherty Laser Vision
4353 Park Terrace Drive, Suite #150
Westlake Village, CA 91361
Tel: (805) 987-5300
Fax: (818) 707-7668
www.doughertylaservision.com

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause or your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices are:

Dougherty Laser Vision
4353 Park Terrace Drive, Suite #150
Westlake Village, CA 91361
Tel: (805) 987-5300
Fax: (818) 707-7668
www.doughertylaservision.com

Effective Date
This notice is effective on or after April 14, 2003