DLV VISION
www.doughertylaservision.com

Westlake Village
4353 Park Terrace Dr Ste. 150
Westlake Village, CA 91361

Camarillo
1821 E Daily Dr.
Camarillo, CA 93010

Simi Valley
2796 Sycamore Dr, Ste. 101
Simi Valley, CA 93065

Encino
16130 Ventura Blvd. Ste. 120
Encino, CA 91436

Newbury Park
1000 Newbury Rd Ste. 220,
Thousand Oaks, CA 91320

Ventura
5682 Telephone Rd. Ste.1
Ventura, CA 93003

WELCOME TO DLV VISION

Who may we thank for referring you to Dougherty Laser Vision?	Advertising:
Friend/Patient: _____ Optometrist/OD: _____ Physician/MD: _____ Organization: _____ Event: _____ Staff Member: _____ Other: _____	

LAST NAME: _____ FIRST NAME: _____ MI: _____

GENDER: _____ 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: _____

Communication Preference: _____

EMAIL ADDRESS: _____

PHARMACY PREFERENCE: _____ PHONE: _____

ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATION: _____

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 DLV Vision and agree to pay all charges incurred. I hereby authorize my insurance company to pay DLV Vision 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. **Return Check**: A **$25** charge will be applied to all return checks.

Date: _____ Signature: _____

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Last Name: _____ First Name: _____ MI: _____

Briefly state the reason for your visit: _____

_____

Do you presently or have you had any problems in the following ares? If "Yes" please explain.

Eyes	**Yes**	**No**	**Explain**
Readness	❑	❑	
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 Degenaration	❑	❑	_____
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:** _____

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Pre-Surgical Cataract Patient Questionnaire

Patient Name: _____
Chart Number: _____
Eye Being Evaluated: ❑ RT ❑ LT

VISUAL FUNCTIONING	Yes	No
Do you have Difficulty, even with glasses, with the following activities?	❑	❑
Reading small print, such as labels on medicine bottles, telephone books, or food labels?	❑	❑
Reading a newspaper or book?	❑	❑
Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	❑	❑
Recognizing people when they are close to you?	❑	❑
Seeing steps, stairs or curbs?	❑	❑
Reading traffic signs, street signs, or store signs?	❑	❑
Doing fine handwork like sewing, knitting, crocheting, or carpentry?	❑	❑
Writing checks or filling out forms?	❑	❑
Playing games such as bingo, dominos, or card games?	❑	❑
Taking part in sports like bowling, handball, tennis, or golf?	❑	❑
Cooking?	❑	❑
Watching television?	❑	❑

SYMPTOMS		
<u>Have you been bothered by</u>?	Yes	No
Poor night vision?	❑	❑
Seeing rings or halos around lights?	❑	❑
Glare caused by headlights or bright sunlight?	❑	❑
Hazy and/or blurry vision?	❑	❑

Advance Notice of Denial

Patient's Name: _____ Date: _____

A comprehensive medical eye examination should include a refraction for glasses. The refraction of 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 **$90.00**.

Do you wish to have a refraction?

❑ Yes
❑ No

Signature: _____ Date: _____

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 ADV 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 healthrelated 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:

DLV 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:

DLV 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

Acknowledgement of Receipt of Notice of Privacy Practices

DLV 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

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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 _____ Type of Plan _____

Effective date of coverage _____ Plan ID Number _____

Secondary Health Plan _____ Type of Plan _____

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 _____

Dear Patients

We have implemented a policy requiring a credit card held on file effective 7/1/2021. We will communicate any balances due and collect your payments at the time of service but if a balance is due after your visit, we will go ahead and automatically charge the credit card on file and you will receive a receipt via email.

FAQS

What about identity theft and privacy?

Under HIPAA, we are under strict rules and guidelines in terms of protecting patient privacy and the credit card is considered protected health information. Because of HIPAA rules, our medical office system is secure as it relates to identity theft.

I don't have a credit card.

You are welcome to leave an HSA (Health Savings Account), Flex Plan or Debit card on file.

What if I have more questions?

Our staff is happy to speak with you about your account at any time.

Credit Card Information

Credit Card: ☐ Visa ☐ Master ☐ Discover ☐ American Express

Full CC Number: _____

Card Holder Name: _____

CVC: _____

Exp: _____

Email for Receipts: _____

Best Contact Phone: _____

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 DLV Vision and/or his providers 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? ❑ YES ❑ NO

If yes, please specify. ❑ 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: _____

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Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
OCT **Fundus Photography** **Topography** **Optos**	**Non-Covered Service**	**$175.00** **$65.00** **$90.00** **$65.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the items or services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / **TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 06/2023) Form Approved OMB No. 0938-0566

Open Payment Database

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

(c) A physician and surgeon shall include in the electronic records for the patient a record of the notice pursuant to this section.

(d) If a physician and surgeon does not maintain electronic records, the physician and surgeon shall include the notice pursuant to this section in the written records.

(e) A physician and surgeon shall give to the patient or patient representative a copy of the signed and dated notice.

663.
(a) (1) Notwithstanding any law, except as provided in subdivision (c), a physician and surgeon shall post in each location where the physician and surgeon practices, in an area that is likely to be seen by all persons who enter the office, an Open Payments database notice.

(2) The Open Payments database notice described in paragraph (1) shall include both of the following:

(A) An internet website link to the Open Payments database.

(B) The following text:

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

(b) Beginning January 1, 2024, if an internet website is used for a physician and surgeon's practice, then the physician and surgeon shall conspicuously post the Open Payments database notice described in subdivision (a) on that internet website, except as otherwise authorized under subdivision (c).]
(c) Notwithstanding subdivisions (a) and (b), if a physician and surgeon subject to this section is employed by a health care employer, the health care employer shall be responsible for meeting the requirements of this section.

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Representative's Name and Relationship (Type or Print)

_____

Patient's Representative's Signature

Original to be maintained in patient's medical records.

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