

Dear Patient:

Welcome to our office! We look forward to seeing that your first visit will be pleasant and rewarding. **The office offers a complete range of eye care from comprehensive eye exams, contact lens services, and eyeglasses to ophthalmologic microsurgery and laser treatment.**

Lasik (Laser Vision Correction) is another specialty service the doctors now offer. Please feel free to contact Leslie Lyssenko, Lasik Coordinator should you have any questions regarding this service.

Your appointment is scheduled for _____ at _____.

Enclosed you will find a Registration Form, Financial Agreement Form and a Patient Medical History Record Form. **Please take the time to fill out all the forms and bring them back with you on the day of the appointment.** The completed forms will help the office serve you more quickly and efficiently. Along with the forms, we ask that you bring the following:

- 1. Current eyeglasses you are wearing.**
- 2. Any eye drops and/or eye medications you are using.**
- 3. Current contact lenses and solutions.**
- 4. Sunglasses if you have them, in case we dilate your eyes.**
- 5. All current insurance cards along with proper authorization or referral forms.**

Due to the constant changes with health insurances, we ask that you call your insurance company prior to the office visit to confirm that you are covered with your current health plan.

Our commitment is to serve you with the highest quality eye care.

Thank you and again, welcome to the office.

Sincerely,

Lee K. Schwartz, M.D.
Thomas M. Swift, O.D.
Margaret P. Liu, M.D.
and Staff at the
Pacific Eye Specialists

DIRECTIONS/PARKING/PUBLIC TRANSPORTATION

WESTBOUND HWY 80 (FROM OAKLAND)

- Take Hwy 80 over the Bay Bridge
- Take the Ninth Street/Civic Center exit, staying in center exit lane, which puts you on Harrison St.
- Travel 1 block on Harrison and turn right onto 9th St. On 9th, get into the left hand lanes labeled “Hayes Street”
- 9th Street will veer left into Hayes St. as you cross Market St.
- From Hayes, turn right onto Franklin (after Van Ness Ave.)
- Continue up Franklin and turn left at California St. (after Bush St.)
- Right on Webster St. (after Buchanan St.)
- 2300 California is immediately on your left.

SOUTHBOUND HWY 101

- From the north, go over the Golden Gate Bridge and follow the overhead signs to downtown
- Follow Lombard St. east and turn right on Webster St.
- 2300 California is on your right.

NORTHBOUND HWY 101 (FROM SAN JOSE)

- From the south via Hwy 101, take Ninth Street/Civic Center exit
- Travel north on 9th St. and get into left hand lanes labeled “Hayes Street”
- 9th Street will veer left into Hayes St. as you cross Market St.
- From Hayes, turn right onto Franklin (after Van Ness St.)
- Continue up Franklin and turn left at California St. (after Bush St.)
- Right on Webster St. (after Buchanan St.)
- 2300 California Street is immediately on your left.

NORTHBOUND HWY 280

- Follow the signs to Golden Gate Bridge
- You will be on the 19th Ave. which becomes Park Presidio Blvd. As you pass through Golden Gate Park
- Turn right on California Street for approximately 2.3 miles
- Turn left on Webster (after Fillmore St.)
- 2300 California is immediately on your left.

PARKING

Directions to the office will lead you to the parking garage on Webster Street. The garage on Clay is accessible by making a left onto Clay Street from Webster. Parking is available directly behind the building as well. The 2300 California garage is entered by continuing down California across Webster. The first driveway on the right enters the parking lot. The parking lot addresses are:

2405 Clay St.
2100 Webster St.
2300 California St.

PARKING FEE is about \$3/hour but is subject to change.

PUBLIC TRANSPORTATION

The 1 California Muni bus stops at the corner of Sacramento and Webster, a half a block from our office. For other Muni information, please call 415-673-MUNI.

AC Transit – 510.817.1717 This is a voice activated system, once the message begins say “Transit” and then “Schedule and trip planning” to speak to an operator.

Golden Gate Transit – 415.923.2000 wait for operator to assist you.

BART – 415-788-BART



PARKING LOT ADDRESSES

- A. 2300 California St.
- B. 2100 Webster St.
- C. 2405 Clay St.

PACIFIC EYE SPECIALISTS
2300 CALIFORNIA ST., SUITE 300
SAN FRANCISCO, CA. 94115

LEE K. SCHWARTZ, M.D.
THOMAS M. SWIFT, O.D.
MARGARET P. LIU, M.D.

PATIENT REGISTRATION

NAME _____ REFERRED BY _____
ADDRESS _____ FAMILY PHYSICIAN _____
CITY _____ ZIP _____ EMPLOYER _____
HOME PHONE _____ EMPLOYER ADDRESS _____
DAYTIME PHONE _____ OCCUPATION _____
EMAIL ADDRESS _____
MARITAL STATUS M S D W NAME OF SPOUSE _____ PHONE _____
SOCIAL SECURITY _____ DATE OF BIRTH _____ AGE _____
PERSON TO CONTACT IN EMERGENCY _____
RELATIONSHIP _____ HOME PHONE _____ WK PHONE _____

INSURANCE: PRESENT CARD TO RECEPTIONIST

Please list the subscriber of the policy if other than the patient. List your primary insurance company first, then any other coverage.

PRIMARY INSURANCE COMPANY _____ ID # _____
MAIN SUBSCRIBER IF OTHER THAN PATIENT _____ DOB _____
SECONDARY INSURANCE COMPANY _____ ID # _____
MAIN SUBSCRIBER IF OTHER THAN PATIENT _____ DOB _____
VISION INSURANCE COMPANY _____ ID # _____
MAIN SUBSCRIBER IF OTHER THAN PATIENT _____ SSN _____ DOB _____
PARTY RESPONSIBLE FOR PAYMENT (if other than patient): _____
I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGE IN MY STATUS OF THE ABOVE INFORMATION.

Signature

Date

Parent (if minor)

Date

PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME _____ TODAY'S DATE _____ BIRTH DATE _____ AGE _____

WHAT IS THE REASON FOR YOUR VISIT TO OUR OFFICE? _____

Please answer the following questions about your medical status and history:

- 1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)
Yes No If YES, please explain: _____
- 2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy eye", retinal detachment)?
Yes No If YES, please explain: _____
- 3. Have you ever had any surgery:
Yes No If YES, please provide date and reason: _____
- 4. Have you ever been hospitalized:
Yes No If YES, please provide date and reason: _____
- 5. Do you take any medications:
Yes No If YES, please list: _____
Do you take any eye medications:
Yes No If YES, please explain: _____
- 6. Do you have any drug or food allergies:
Yes No If YES, please list: _____
- 7. Please circle if you have: Asthma, Diabetes, High Blood Pressure, Arthritis, Thyroid, or Immune System Diseases
- 8. Are you taking Flomax? YES NO

Review of Systems

	Yes	No	If YES, please explain
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye disease run in your family: (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes No If YES please explain _____

Do you smoke? If YES, how much? drink alcohol? If YES, how much?

PLEASE CIRCLE IF YOU USE: GLASSES CONTACT LENSES

PLEASE CIRCLE IF YOU ARE HERE FOR OF IF YOU ARE INTERESTED IN:

NEW GLASSES CONTACT LENSES CONSULT LASER VISION CORRECTION CONSULT

DOCTOR'S SIGNATURE _____ DATE _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible eye care. If you have medical or vision insurance, we are deeply committed to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Many insurance plans require that the patient pay a co-payment at the time of service. We are not allowed to defer, waive or disregard these payments. Please be prepared to settle these charges at the time of your visit or else you may need to reschedule. We accept cash, checks, credit cards and ATM/Debit cards for your convenience. Charges not paid at time of service will be billed with additional \$10 billing fee.

Return checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½% per month. **Charges may also be made for broken appointments depending on your cancellation history. The fee for this is \$25.**

We will gladly submit your claim to your insurance company but you must realize, however, that:

- 1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.**
- 2. Please call your insurance company prior to your office visit regarding your coverage and benefits. Verification of coverage is not a guarantee of payment. Payment is determined upon the submission of the claim.**
- 3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Such services include but are not limited to refraction, laser vision correction, contact lens consultations and materials, optical services, and cosmetic surgery. We are happy to provide all the services you may need but we request that non-covered service charges be settled at the time treatment is rendered.**
- 4. Refraction is one of the most important part of your eye exam. This is the part of the exam by which we determine whether you can be helped in any way by new eyeglass prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is not a covered service by Medicare and many other insurance plans. These plans consider refraction as a “vision” service not a “medical” service. Our office fee for refraction is \$85 and it is our office policy to collect this fee at the time of service in addition to any copayment your plan may require.**
- 5. Contact Lens Services is not included in the standard eye exam. Contact lens services consist of contact lens fitting, consultations, prescriptions and lens replacements. We are happy to provide any services related to contact lens usage, but separate fees will be charged.**

We must emphasize that, as medical/vision care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

We understand that these insurance related matters may be confusing to you, and that is why we prepared this statement. If you have any questions regarding your insurance policy, coverage or plan, please contact your insurance company directly. They will better assist you in terms of your contract with them.

Thank you.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY DRS. LEE SCHWARTZ, THOMAS SWIFT AND MARGARET LIU. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO DRS. LEE SCHWARTZ, THOMAS SWIFT AND MARGARET LIU.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION.

Signed _____ Date _____

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to:

Pacific Eye Specialists
Attn: Medical Records
2300 California Street, Suite 300
San Francisco, Calif. 94115
Tel: (415) 921-7555 Fax: (415) 921-1475

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to:

Pacific Eye Specialists
Attn: Medical Chart
2300 California Street, Suite 300
San Francisco, Calif. 94115
Tel: (415) 921-7555 Fax: (415) 921-1475

You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact:

Pacific Eye Specialists
Attn: Complaint Department
2300 California Street, Suite 300
San Francisco, Calif. 94115
Tel: (415) 921-7555 Fax: (415) 921-1475

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Pacific Eye Specialists
Attn: Office Administrator
2300 California Street, Suite 300
San Francisco, Calif. 94115
Tel: (415) 921-7555 Fax: (415) 921-1475

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have been presented with a copy of Pacific Eye Specialists Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:
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