FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Patient Demographics

Patient Information

Legal Name: _____ Date: _____

Nickname: _____ Sex: M F Other Birthdate: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Marital Status: S M W D Social Security # (for medical insurance purposes): _____

Parent or Guardian's Name (If Minor): _____

Emergency Contact: _____ Phone Number: _____

Employer

Name: _____ Address: _____

Commercial Medical and Vision Insurance: We are an **out-of-network** provider. We will provide you a super-bill for you to send into to your insurance company.

Medicare Number: _____ **Secondary Insurance: _____**

Name of Member: _____ **Member's Birthdate: _____**

Person Responsible For Payment If Not the Patient

Name: _____ Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Doctor

Name: _____ Phone Number: _____

Primary Doctor

Name: _____ Phone Number: _____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921

FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Medical History Questionnaire (page 1)

Name: _____ Date of birth: _____

Today's date: _____ Date of last eye exam: _____

Medications

List all ORAL or topical Skin medications you are currently taking:

_____

_____

List all EYEDROPs you are currently taking:

_____

_____

Do you have allergies to any medications? Y N If yes, list the medications: _____

_____

Major Problem Medical History

List all major illnesses and injuries: _____

List any surgeries (Eye and non-eye) you have had:

_____

Have you ever had a blood transfusion? Y N

Family History

Please circle any of the condition below of which you have a family history and tell us who in your family was afflicted:

Blindness_____ Cataracts_____ Glaucoma_____ Macular Degeneration_____

Diabetes_____ Hypertension_____ Heart Disease_____ Stroke_____

Cancer_____ Thyroid Disease_____ Arthritis_____ Other_____

Social History

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? Y N

Do you smoke? Y N If yes how much? _____ For how long? _____

Do you drink alcohol? Y N If yes how much? _____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921

FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Medical History Questionnaire (page 2)

What is your profession? _____

Do have or have been told you have DRY EYES? YES NO If yes, what are your symptoms?

_____

Do you currently have any problems in the following areas? If yes, please provide additional details.

	Yes	No	Details
Eyes			
Ears, Nose, Throat			
Cardiovascular (high BP, racing pulse etc)			
Respiratory (congestion, wheezing etc)			
Gastrointestinal (constipation, ulcers etc)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Skin			
Neurological (seizures, paralysis etc)			
Psychiatric			
Endocrine (diabetes, hypothyroid etc)			
Blood, Lymph (anemia, bleeding etc)			
Allergic, Immunologic (hives, lupus etc)			
General (fever, fatigue, weight loss etc)			
Pregnant or Nursing?			

Physician's Signature _____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921

FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Signature on File, Assignment of Benefits, Financial Agreement

1. **Release of Information:** Harvey A. Fishman, MD, APC may disclose all or any part 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 Harvey A. Fishman, MD, APC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Harvey A. Fishman, MD, APC 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 of the original.

2. **Other Insurance:** I understand that Harvey A. Fishman, MD, APC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Harvey A. Fishman, MD, APC 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 Harvey A. Fishman, MD, APC if I belong to a plan that does not appear on the above mentioned list.

3. **Non-Covered Services:** I understand that Harvey A. Fishman, MD, APC's contracts with health care service plans relate only to 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 non-covered services include, but are not limited to, services not specified as being covered in the patient's contracts with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatments or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Harvey A. Fishman, MD, APC to obtain necessary service plan authorizations.

4. **Financial Agreement**: I agree that in return for the services provided to the patient by Harvey A. Fishman, MD, APC I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Harvey A. Fishman, MD, APC for payment. I understand that I am financially responsible for all charges whether or not they are covered by any insurance. 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 Harvey A. Fishman, MD, APC. If copayments and or deductibles are designated by my insurance company or health plan, I agree to pay them to Harvey A. Fishman, MD, APC. However, it is understood that the undersigned and/or the patient are primarily responsible for payment of my bill.

Signature_____ Printed name_____ Date_____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921

FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Refraction Policy

Upon your visit to the practice of Harvey Fishman, MD, PhD it is medically necessary to perform a refraction. A refraction is the part of the medical exam by which we determine whether you can be corrected to 20/20 (perfect) vision with the help of lenses. It is one of the most important parts of the exam because if you are NOT correctable to 20/20 vision in each eye, there is a medical problem with your vision and/or your health.

While the American Academy of Ophthalmology (AAO) and American Board of Ophthalmology (ABO) regard the refraction as an essential part of the medical exam, Medicare **NEVER** covers a refraction and is statutorily excluded.

PLEASE NOTE: Medicare does NOT cover these charges but does require by law that we bill for all services performed.

For all new patients and for established full/yearly exams, we will be performing a refraction unless you specifically request not to have it performed. We are happy to help you submit the refraction charge to VSP or another vision insurance as an out-of-network provider.

The cost for the refraction is $220. You may ask that refraction is not be performed, however please consider that they are necessary in determining the following:

- Diagnosis of medical causes of vision loss
- Glasses prescriptions
- Contact lens prescriptions

Acknowledgement

I have read the above information and I understand that my refraction is a non-covered service through Medicare. I accept full financial responsibility for the costs of refraction and agree to pay the amounts of $220. Any medicare co-payments or payments for additional non-covered services are separate from these charges.

Patient Signature_____ Date_____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921

FISHMANVISION
COMPREHENSIVE OPHTHALMOLOGY

Acknowledgement of Receipt of Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices to read. I consent to the use of my protected health information for treatment, payment, and health care operation. I give Harvey A. Fishman, M.D, A Professional Corporation and its staff permission to discuss my care with my family members or close friends if necessary.

Please add any exceptions to this permission here: _____

_____

Name of Patient: _____ Date: _____

Signature of Patient: _____

Signature of Patient Representative (Required if patient is unable to sign this form):

_____

Relationship of Patient Representative to Patient: _____

E-mail and Text Message Authorization

I want to communicate via email and/or text message with Dr. Harvey Fishman, M.D, APC on matters of my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of the workforce members, liable for loss of any confidentiality associated with information transmitted via email and/or text message. I also understand that it is not the policy of the practice to encrypt any confidential health information I request to be sent to me via email and/or text message. Because this information is not encrypted I understand that it is not secure. I acknowledge this is a risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name of Patient: _____ Date: _____

Signature of Patient: _____

706 Webster St.
Palo Alto, CA, 94301

P: 650-322-4393
F: 650-322-1921