AvantiEye

WELCOME TO AVANTI EYE

Our physicians and staff are committed to your care and comfort. If there is anything we can do to help you, please let us know.

Registration and Medical History:

Please take a few minutes to review the enclosed paperwork. This will help us provide the best possible service to you. It is very important that we receive insurance information for both your primary and secondary insurance (if applicable). We will need to copy any insurance cards for our records. As many medical conditions and medications can affect the health of your eyes, we ask that you take the time to fill out the Medical History as well. The best medical care can be provided only on the basis of mutual understanding.

Insurance and Billing Policies:

In order to make your financial obligations to our office and keep the necessary insurance paperwork as simple as possible, we ask that you observe the following policies:

- We participate in a variety of insurance plans, and our billing department will bill all insurances providing we have all your insurance information on file. An inquiry of your benefits, copayment and/or deductible may be submitted to your insurance prior to your appointment and all applicable co-payments and any unmet deductible are due at the time of service. Understand that You the patient are ultimately responsible for securing payment for your medical care. Services not covered by your insurance are your responsibility.
- So that you are fully aware of what to expect regarding your financial responsibility, check your insurance handbook for benefit information prior to scheduling an appointment. In particular, you want to know if the doctor is a participating provider of your plan, if you have vision benefits, if you need to optain a referral from your primary care provider, what is your financial responsibility at the time of service, and if your plan is current.
- If the doctor is not a participating provider or your plan, understand that payment in full is required at the time of service. We will assist you in filing a claim with your carrier.
- We are participating providers under Medicare. This means we accept the fees set by Medicare for medical services covered by the Medicare program, including surgery. All claims will be filed to Medicare. Medicare does not cover routine eye exams and refractions and payment for refraction is required at time of service.
- Some health plans require you to obtain authorization for services from your primary care provider (internist, family physician, etc.). It is your responsibility to obtain authorization from your primary care provider. This is required by your insurance before you visit our office, even when the visit if for an urgent problem. Contact your insurance company if you have any questions.
- If you have State of California medical coverage (MEDI-CAL), there will be no copayment of deductible UNLESS you have a share of cost responsibility determined by the State.
- Payment for a routine eye exam will be expected at the time of service. It there are no medical findings/diagnosis upon completion of your eye exam, then billing will indicate "a routine exam" and payment will be expected from you.
- Before any surgical procedure or exam, which may entail greater expense, our office will provide insurance coverage information and an **estimate** of what, if any, balances you may be responsible for.
- We use standard criteria for determining our basic fee, i.e. type and extent of examination whether you are new or established patient, complexity of your eye problem, materials used, the use of specific skills, instrumentation and equipment to diagnose and manage your present condition.
- Balances on accounts are to be paid within 30-days of when the statement is issued. A patient balance will be mailed to you after the insurance company pays its portion of the bill. If the balance remains unpaid after 30-days, a late charge of 5% will be assessed and applied to delayed payment account.
- All copays are to be paid at the time of service; this is an insurance company policy. If the copay is not paid at the time of service, you will be assessed a $10 fee.

- Any and all 60 days and older overdue accounts will be assessed a $10 late fee each month of delayed payment. Accounts in excess of 90-days will be referred to an outside collection agency. Your signature below constitutes an understanding of this policy and waiver of confidentiality for the purposes of fee collection.
- MEDICAL RECORDS: We will provide you a copy of your medical records upon request of a fee of $15. A signed "medical release" form is required. Please allow our office 7-10 days for the completion of your request.
- FORMS/REPORTS: A minimum charge of $25-$50 depending on the length of time of the form/report will be required for completion of any forms or reports to outside sources. Payment is due prior to form completion. Please allow our office 7-10 days for the completion of your request.
- A $35 charge will be added to your account for any check returned by your bank for any reason.
- If it becomes necessary to assign your account to an attorney for collection and /or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection procedures.

By signing below, I have read and understand the above policies and I understand that I am financially responsible for all charges whether or not covered by my insurance.

I request that payment of my insurance benefits be made payable directly to Juliet Del Piero, MD Inc for any services furnished to me by Avanti Eye. I authorize any holder of medical information about me to release to the insurance carrier any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it.

_____ _____

PATIENT SIGNATURE (IF PATIENT IS A MINOR, GUARDIAN MUST SIGN) DATE

NEW PATIENT REGISTRATION INFORMATION

PERSONAL INFORMATION:

Name: _____ Date: _____

Date of Birth _____ Age __ M / F _ SS# _____ DL# _____

Address _____

Street City State Zip

Phone Home (___) _____

Cell (___) _____

Email _____

_____

Occupation _____ Employer _____

Work Address _____Wk Phone (___)_____

Marital Status SINGLE MARRIED WIDOWED DIVORCED

Spouse Name _____ Date of Birth __
Employer ___ Address _____ Ph # __

Complete if patient is under 18 years of age:

Name of Father ____ Date of Birth __ Phone # ( )___ Father's Employer ___ Address _____

Name of Mother ___ Date of Birth __ Phone # ( )___ Mother's Employer ___ Address _____

REFERRED BY: Friend / Relative _ Doctor _____
Name Name

Yellow Pages Television Internet Other _

INSURANCE INFORMATION:

Medicare # _ Medi-cal / CCS # ____
Workers' Compensation **(Job Injury)** to whom is bill sent? _
Other Medical Insurance ___

ID # _____ Group # _____

Name / Address of 2nd Insurance _____

ID # _ Group # _____

RESPONSIBLE PARTY: Are you responsible for payment? YES NO If not, list responsible party below:

Name . Relationship __ DOB _
Address _____ Ph # ( )_____

EMERGENCY CONTACT:

Name _____ Relationship _____ Address _____Ph # (___)_____ Cell # _(
)_____ Wk # (___)___

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. I request that payment of authorized Medicare and / or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, it's agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

PATIENT SIGNATURE (IF PATIENT IS A MINOR, GUARDIAN MUST SIGN) **DATE**

MEDICAL HISTORY QUESTIONNAIRE

NAME: **DATE:**

Who is your Primary Care Physician? _____ Last eye exam: _____
List all medications, supplements, & vitamins you currently take:

Do you have any allergies to medications: YES NO **If YES, please list the medications: _____**

Check all major illnesses: Heart Disease Diabetes Heart Attack Stroke High Blood Pressure High Cholesterol Cancer Thyroid Arthritis HIV/AIDS Hepatitis Macular Degeneration Glaucoma Kidney Disease Retinal Detachment Cataract Blindness

What are your current concerns / symptoms relating to your eyes:

Do you *currently* have any problems in the following areas:

If YES, please provide more information	**YES**	**NO**	**Details**
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc)			
CARDIOVASCULAR (High BP, racing pulse, etc)			
RESPIRATORY (congestion, wheezing, etc)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation)			

(continued) If YES, please provide information	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc)			
SKIN (pimples, warts, growths, rash, etc)			
NEUROLOGICAL (numbness, headache, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc)			
BLOOD / LYMPH (cholesterolemia, anemia, etc)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc)			

FAMILY HISTORY

M = mother **F** = father **S** = sibling **GP** = grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation:

Education: High School Vocational School College Degree

Marital Status : Married Divorced Single Widowed

Living Arrangements:

	YES	NO	Details
Do you drive?			
Do you have difficult when driving?			
Do you have problems with night vision?			
Do you wear glasses?			How old are they?
Do you currently wear contact lenses?			Brand: Power:

Do you drink alcohol?	YES NO	If YES:	Occasional	1 / day	2-3 / day	4+ / day
Do you smoke?	YES NO	If YES:	Occasional	½ pack / day	1 pack / day	1+ pack / day
Do you use illegal substances?	YES NO	If YES:	What do you use?		What is the frequency:	

PATIENT SIGNATURE (IF PATIENT IS A MINOR, GUARDIAN MUST SIGN) **DATE**

NOTICE OF PRIVACY POLICIES FOR
AVANTI EYE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Avanti Eye, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective **April 5, 2023** and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Avanti Eye; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatment. This information often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research. -
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, a better understanding who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the property of Avanti Eye, the information belongs to you.
You have the right to:

- Obtain a paper copy of this notice of information practices on request.
- Inspect and receive a copy of your health record as provided for in 45 CFR 164.5 24.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 FR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Avanti Eye is required to:

• Maintain the privacy of your health information.
• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
• Abide by the terms of this notice.
• Notify you if we are unable to agree to a requested restriction and
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us with.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Jennifer Mullett in Monterey at 831-375-2486. Office specific questions should be directed to the appropriate office, Monterey 831-375-2486, Carmel Valley 831-625-3911, or Soledad 831-678-2086.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY PRACTICES** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Signature of Patient: _____

Print Name of Patient: _____

Date Notice Signed: _____

Notice Effective Date: May 5, 2023

AvantiEye

CANCELLATION, MISSED ("NO SHOW") AND LATE ARRIVAL TO APPOINTMENT POLICY

We, at Avanti Eye Center, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies, however, "No shows" and "Late Cancellations" cause problems that go beyond a financial impact on our practice. "Late Cancellations", "No Show" and even arriving more than 15 minutes late to your appointment, create inconvenience and prevents another patient from scheduling or being seen on a timely basis.

Aside from the appointment card given at the time of your last appointment, we, as a courtesy, and to remind patents of their scheduled appointment, offer the patient ample time to confirm their appointments. An automated appointment reminder is sent at least 48 hours prior to the scheduled appointment time, followed by a call from our office staff if there is no response by the patient to the automated reminder.

The following, details the policy.

Office visits: $25 fee will be charged for each no-show or late cancellation if notice is given less than 24 business hours of your scheduled appointment.

Minor Procedures: $150 fee will be charged for each no-show or late cancellation if notice is given less than 48 business hours of the scheduled arrival time.

Late Show: Arriving more than 15 mins late of the scheduled time is considered a "Late, No Show". The Doctor may not be able to accommodate you. In that case, your appointment may be rescheduled.

Business hours are: Monterey: Monday-Friday between 9:00 am and 5:00 pm. Carmel Valley: Monday – Friday 9:00 am – 5:30 pm. Soledad: 8:30 am – 5:30 pm. Excluding holidays.

MONTEREY TELEPHONE NUMBER: 831 375-2486
CARMEL VALLEY TELEPHONE NUMBER: 831-625-3911
SOLEDAD TELEPHONE NUMBER: 831-678-2086

Thank you for your understanding and cooperation as we strive to best serve the needs of **all** of our patients.

I have read and understand the terms of these policies. I agree to comply with the terms set forth in this policy for services rendered by Avanti Eye Center.

By signing below, you acknowledge that you have received a copy of the "No Show/Late Cancellation/Late Show specifics and understand its entirety.

_____ _____
Printed Name Date

_____
Signature

VSP COORDINATION OF BENEFITS ACKNOWLEDGEMENT

AvantiEye

Juliet Del Piero, M.D. Ronald Friedman, M.D. Ashley Park, O.D.
Kim Hartford, O.D. Irv Hartford, O.D.

Date: _____

Patient Name: _____

I acknowledge that if I have VSP

The doctor will submit a claim to VSP for all covered vision services that have been provided.
Depending on the eye examination today, the doctor may coordinate coverage with my VSP benefit and other VSP benefits or other insurance plan(s) that I have coverage with.
This will use my VSP vision benefit for the current eligibility period.

_____ _____
Patient Signature Date

If you have questions about your VSP benefit, please call
VSP Member Services at: (800) 877-7195

Monterey
Juliet Del Piero, MD & Ronald Friedman, MD
80 Garden Court, Ste 103
Monterey, CA 93940
Ph: 831-375-2486
Fax: 831-375-0128

Carmel Valley
Kim Hartford, OD & Irv Hartford, OD
14 Ford Road
Carmel Valley, CA 93924
Ph: 831-625-3911
Fax: 831-298-7634

Soledad
Ashley Park, OD
179 Main Street
Soledad, CA 93960
Ph: 831-678-2086
Fax: 831-678-9264

www.avantieye.com