

Date:(*PLEASE PI	RINT YOUR NAME AS IT APPEA	ARS ON YOUR INSURANCE CARD)
Last:	First:	MI:
Local address:		
City:		
Second address:		
Date of birth:		
Marital status: (circle answer) M	inor Married Single Sepa	rated Divorced Widow(er)
Social Security #:		
Preferred Phone #: ()		
Emergency contact name & phon		
Occupation:		
Language: Race		
Referred by: (circle answer) Opto	ometrist Ophthalmologist F ewspaper Insurance Famil	Physician TV Radio Internet
Name of Individual Referring:		
	HIPAA CONTACT LIST	
Katzen Eye Care and Laser Center, its As members/friends in reference to my med	ssociates and Staff have my permi dical care:	ission to speak to the following family
	_Relationship:	Phone:
	_Relationship:	Phone:
Katzen Eye Care and Laser Center, its As	sociates and Staff have my permis	ssion to leave a message on my home
answering machineYES NO, a		
I have received and read a copy Laser Center.	of the Notice of Privacy Pra	actice of Katzen Eye Care and
XSignature		

MEDICAL HISTORY QUESTIONNAIRE

DATE: NA	AME:	D.O.B.:	
Primary Care Physician:			
		Phone #:	
PHARMACY NAME:			
PHARMACY PHONE #:			
	PLEASE CIRCLE	ALL THAT APPLY TO YO	DU:
Patient's	past / present EYE history:	Date of last exam:	
NONE	Cataract	Flashes / floaters	Thyroid eye disease
Glasses / readers	Cataract surgery	Retinal tear / detachment	Dry / itchy / red / watery eyes
Contact lenses	High eye pressure	Retinal surgery / laser	Headache / Migraine
Corneal problems	Glaucoma / surgery	Macular degeneration	Styes / chalazion
Lazy eye	Glare / Halos	Eye injections	Blurry / cloudy vision
Muscle problems / surgery	Light sensitivity		
*Do you need a new eyeglas		O (PLEASE SEE REFRACTION	INFORMATION FORM)
	ledical History: Date of Last		
NONE, good health	Irregular heart rate	Chemo therapy / radiation	Thyroid disease / Grave's
Diabetes	Asthma	Lupus	Kidney disease
Hypertension	Breathing trouble	Rheumatoid arthritis	Anxiety / Depression
Congestive heart failure	Emphysema	On Plaquenil	Mental illness
Bypass or stent	Auto immune disease	Dementia / Alzheimer's	MRSA (staph infection)
Pacemaker or Defibrillator	Cancer	Blood thinner use	Parkinson's
Stroke / TIA	Cancer Surgery	Other:	
High Cholesterol			
Do you smoke?YES		_ Do you drink alcohol?YE	SNO How much?
Do you use drugs?YES			
		disease and health problems:	5.5.11.1
NONE KNOWN	Keratoconus	Corneal problem	Retinal detachment
Glaucoma	Crossed eye	Amblyopia (lazy eye)	Macular degeneration
Blindness	Hypertension	Heart disease	Cancer:
Diabetes	Other:	h. h ! ! ! ! ! ! ! ! !-	
		ly have any problems in the foll	
Ear, Nose, and or Throat			
Cardiovascular			
Respiratory			
Gastro-intestinal			
Urinary			
Skin			
Muscle			
Neurological			
Psychiatric		ITE BELOW THIS LINE	
	DO NOT WRI	ILE DELOW I LIS LINE	
Took Cignature		MD/OD Signature	
rech Signature		MD/OD Signature	

KATZEN EYE CARE & LASER CENTER

MEDICATIONS

PATIENT NAME	DATE			
NONE				
MEDICATION NAME STRENGTH/MG	ORAL/TOPICAL/INJ	FREQUENCY		
ALLERGY INFORMATION NO KNOWN DRUG ALLERGIES	– PLEASE LIST ALL ALLERG	SIES:		



KATZEN EYE CARE AND LASER CENTER INSURANCE AND FINANCIAL

Insured Name: Insured D.O.B.: Secondary Insurance Company: ID #: Insured Name: Insured D.O.B.: Insured Name: Insured D.O.B.: PLEASE READ: YOU are responsible for payment in full at the time services are rendered. ALL INSURANCE & LIFETIME MEDICARE B SIGNATURE AUTHORIZATION FOR SERVICES STARTING DATE: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Non-covered services: I understand that certain services including, but not limited to, normal eye exams, REFRACTIONS (determination of prescriptions for eyeglasses and contact lenses), contact lenses, supplies, letters and research are not covered by Medicare, most insurers, PPOs and prepaid health plans. I agree to pay for these services personally. Covered services: I understand that almost all insurances, Medicare, PPOs and HMOs have a deductible and copayment which they do not cover. These deductibles and copayments are my direct responsibility and I will pay for these at the time services are rendered. If it becomes necessary to effect collection of this account, I agree to pay all costs and expenses including designated attorney's fees. I hereby verify that I have received the Notice of Privacy Practices.		
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REFRACTION AT KATZEN EYE CARE & LASER CENTER

WHAT IS A REFRACTION?

Refraction is the procedure or test that determines the best distance and reading vision your eyes can achieve, both with and without glasses or contacts.

WHY IS PERFORMING A REFRACTION NECESSARY?

Refraction is the first step in an evaluation of your eye health, especially if you are experiencing blurred or decreased vision.

If your vision is not 20/20, Refraction is needed to determine if you have a medical problem, or if you simply need a prescription for glasses.

Refraction is necessary to answer the following questions: Is my current glasses prescription correct? Will new glasses help me see better?

Refraction is necessary to determine if cataract surgery is needed to improve your vision, or if your vision can be improved by just changing the corrective prescription for your glasses. The Refraction will document the medical necessity for cataract surgery and verify the need for coverage by insurance companies.

WHO PERFORMS THE REFRACTION?

We perform a refraction using any of several precise and highly technical instruments. The resulting information is evaluated by the expertise of our physicians and certified ophthalmic assistants.

DOES MY INSURANCE COVER THE COST OF THE REFRACTION?

NO. Medicare and most insurance companies DO NOT cover the charge for Refraction.

If you need the Refraction Test, a doctor or technician will notify you in advance, and you will have the chance to decline the service. However, you need to understand that if you decline, we may not be able to determine the cause for your decrease in vision.

The charge for the Refraction Test is \$75.00; the fee is due when the service is rendered and covers the time, expertise, and effort in performing this procedure.

After performing the Refraction Test, we will give you a copy of your prescription, both for your records and to update your glasses if necessary.

We hope this helps you understand the reasons for the Refraction Test and the necessary charge. We are happy to answer any questions you may still have.

Acknowledgement:

I have read the above and understand that the Refraction Test is a non-covered service. If it is necessary, I accept full financial responsibility for the cost of the procedure.

Patient Signature	Date

CHOICE OF INTRAOCULAR LENS

When the eye's natural lens clouds, a cataract operation can remove the cloudy lens and replace it with an artificial Intraocular Lens (IOL). The IOL allows the eye to focus. Modern medicine has given us several choices:

Fixed Focus Intraocular Lens has been used for over 50 years and corrects vision to a single, fixed focus. Patients with a fixed focus lens often need glasses for distance, and/or intermediate and near.

High Definition Aspheric Lens has been used for about 10 years. This lens usually corrects distance vision. This lens can restore the functional vision to that of a young adult. This can provide additional safety when driving at night.

This lens gives the best vision at one distance only – usually far away.

Toric Intraocular Lens - Patients with astigmatism will require a Toric Intraocular lens to obtain clear distance vision. They still will need glasses for near, intermediate or both.

Accommodating Intraocular Lens (Crystalens) uses the eye's natural muscle to change focus for different distances giving the most natural vision. This IOL allows most patients to regain some focus for near tasks. Vision quality is very good since the optic is the same as the Fixed Focus Intraocular Lens. It works by having very flexible legs inserted into the eye muscles which allow the lens to move back and forth to focus. It may take as much as a year for the muscle to gain strength enough to focus and you will probably need glasses for some near tasks. In addition to excellent distance and quality of vision, this lens gives vision at intermediate ranged i.e. watch, cell phone, computer, grocery shopping, speedometer, AND many patients also get good reading vision.

Multifocal Intraocular Lens (ReSTOR and Tecnis Multifocal) are like trifocals in that they have steps or rings cut into the lens. Because they split light rays, you are actually looking at several different areas at the same time. Glare and halos from these rings may cause difficulty with night driving. The brain usually learns to adapt to these images with time. Additionally, because the light is split, less light gets to any particular point, resulting in a loss of quality in low light.

These give good distance and near focus although there is some loss of quality and contrast.

Costs

Medicare and most insurances cover the **Fixed Focus Intraocular Lens** after cataract removal. Intraocular Implants used to correct astigmatism, near and intermediate vision are not covered and must be paid by you personally. Payment for the additional cost may be made with cash, check, Visa, MasterCard, Discover or a financing plan. The additional cost is comparable to a dental bridge, caps on your teeth, or dental implants.

Please turn over and answer questions to help the doctor recommend which lens will be best for you.

Cataract and Refractive Lens Exchange Questionnaire

There are several new intraocular lens options available for cataract surgery that can reduce or eliminate the need for glasses or contacts. Please answer all of the following quesitons to assist the doctor in determining the treatment best suited to meet your visual needs.

		well at distance without gl	asses after surg	ery?
Yes, I w	ould prefer no d	istance glasses. t to me. I would not mind v	vearing distanc	e glasses.
No, that	is not important	t to me. I would not inmid v	vearing distance	o granoco.
2. Are you inte	rested in seeing	well at near without glasse	s after surgery	?
	vould prefer no r			
No, tha	t is not importan	t to me. I would not mind v	wearing reading	glasses.
3. Visual Need	S			
		ost important to you? Plea	se choose only	one of the
		near, intermediate, or far.		
Near		Intermediate		Far
Sewing	OR	Computer	OR	Driving
Reading a book		Menus	Na.	Movies
Reading a News		Cooking		TV
reducing a record	-Park			
near vision see some h Yes 6. If you coul and good c compromis would you	d have good dist alos around light d have good dist omputer distance was that you n like that option?	tance vision during the dace (Intermediate) vision winight need glasses for reading	omise was that that option? y and night w thout glasses, the	you might ithout glasses, but the
Yes		_ No		
		owing scale to describe you		
			Tech I	nitials
Patient's Signa	ature	Date		
ON CHEST SERVICE CO. C. C. C. C.			MDs I	nitials

KATZEN EYE CARE AND LASER CENTER

Patient Name: PLEASE CIRCLE YOUR RESPONSE	ON EACH LINE		
PLEASE LEAVE BLANK IF IT DOES NOT			
lave you been bothered by:	Ans	wer	Comments
Overall decline in vision	YES	NO	
Blurry Vision	YES	NO	
Glare or poor night vision	YES	NO	
Sensitivity to light	YES	NO	
Seeing rings or halos around lights	YES	NO	
Seeing double	YES	NO	
lave you noticed a decrease n your vision when you:	Ans	wer	Comments
Drive during daylight hours	YES	NO	
Drive during nighttime hours	YES	NO	
See traffic or road signs	YES	NO	
Read newspapers or telephone books	YES	NO	
Read labels, price tags, or medicine bottles	YES	NO	
Use a computer	YES	NO	
Do fine handwork or hobbies	YES	NO	
Look at colors	YES	NO	
Sew, cook or work around the house	YES	NO	
Play cards	YES	NO	
Watch TV	YES	NO	
	YES	NO	
Look at steps or curbs	1123		
Look at steps or curbs Work at your job	YES	NO	
- Andrews Color Waterland, State Manager	200000	NO NO	

Patient Signature: ___

Date: _