

Thank you for choosing our office to care for all your vision needs. We are delighted to welcome you to our practice, and appreciate the opportunity to provide you with the highest quality eye care in an exceptional setting.

Our desire is to enter into a partnership with you based on trust and mutual responsibility. Please know that your needs come first in our practice, and our commitment to you is to provide you with the best care to ensure the long-term health of your eyes.

Our patient registration and medical history forms are enclosed. Please complete these forms and bring them with you to your appointment. The information on this will help us serve you better. Also, please bring your insurance card and your glasses or contact lenses. For your convenience, we have also enclosed an appointment card below confirming your visit with us.

We look forward to meeting you. Because this time has been reserved specially to meet your needs, we thank you in advance for honoring your appointment. If you have any questions for us prior to this visit, please do not hesitate to call. Again, thank you for choosing our office for all your eye care needs. We look forward to a long and rewarding relationship.

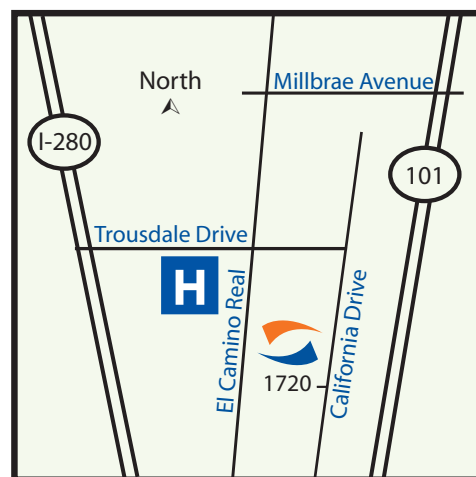
Sincerely,

*Drs. Kenneth Chern and Edward Koo and the
Staff of Peninsula Ophthalmology Group*

DIRECTIONS TO OUR OFFICE

FROM HIGHWAY 101: Take the **Millbrae Avenue** exit heading west. Turn left at **El Camino Real**. At the 2nd light, turn left onto **Trousdale Drive**, then right onto **California Drive**. Turn right into the parking garage for the 1720 building and park on **Level C**. The walkway takes you to our floor; we are in **Suite 225**.

FROM INTERSTATE 280: Take the **Trousdale Drive** exit heading east. Cross **El Camino Real** and turn right onto **California Drive**. Turn right into the parking garage for the 1720 building and park on **Level C**. The walkway takes you to our floor; we are in **Suite 225**.



Important Information on Co-payments and Additional Service Fees

Welcome and thank you for choosing Peninsula Ophthalmology Group for all your eye care needs. It is our goal to work with you to help you understand and maximize your eye insurance benefits.

Unfortunately, eye insurance, whether medical or vision, has been made needlessly complex by the insurance industry. Our office strives to diligently stay abreast of the ever changing rules and regulations which we are contractually obligated to follow. In fact, there are over a thousand different insurance plans in the Bay Area and it is difficult to always know what is or is not covered by any particular plan. Our office therefore highly recommends that each of our patients find out exactly **what their individual eye insurance covers in advance** so that there will be no confusion on the day of your visit.

Co-payments

Almost all insurances now require a co-payment to see a specialist. Please check with your insurance company prior to your visit to verify the amount of your specialist co-payment. This may be a different amount from your primary care co-payment. Co-payments are collected when you check-in. There is an additional service fee of \$25 if you prefer to have us bill you for your co-payment.

Refraction

The majority of health insurances **no longer cover** the checking and updating of your eyeglass prescription known as the “**Refraction.**” Our office recommends getting a refraction once a year or if you feel your vision has changed. This helps ensure that you can see the clearest that you are able. If you wish to have your eyeglasses checked and your prescription updated, please inform the front desk at check-in. There is a charge of \$50 for this service if it is not covered by your insurance.

Contact Lens Services

Some vision insurance plans cover only the refraction and do not cover any contact lens services such as the annual contact lens evaluation or contact lens fittings. If you would like an updated contact lens prescription, we are required by law to perform an annual contact lens evaluation in order to document that your contacts are still fitting correctly. This is because contact lenses are considered medical devices and are regulated by the FDA. Please check with your vision insurance company to see if contact lens services are covered by your vision plan. Some plans require you to go to a retail optical vendor such as JC Penney’s or Sears for all your eyeglass and contact lens services. If not covered by your plan, the cost for an annual contact lens evaluation is \$35. The cost for contact lens fittings vary by the complexity and type of contact lens fitting requested. Our front desk staff would be happy to discuss the details with you.

☎ 650.697.3200

☎ 650.697.3203

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Age:** _____ **Today's Date:** _____

Your **Primary Care Doctor's** name: _____

PAST MEDICAL HISTORY

Allergies: (List all medications that have caused an allergic reaction) [**None**]

List all medications you take: (including over the counter medications, vitamins and supplements)

[**None**] _____

List all eye drops you take: (including artificial tears and over-the-counter drops)

[**None**] _____

List all major illnesses and injuries: (diabetes, hypertension, thyroid, asthma, heart disease, cholesterol)

[**None**] _____

List all past surgeries: [**None**] _____

List all hospitalizations (past 3 yrs): [**None**] _____

If applicable, are you pregnant? No Yes : _____ Months

Have you had any of these eye conditions in the past: (circle) [**None]**

Glaucoma Cataract Crossed eyes Lazy eye Eye injury

Bulging eyes Retinal problems Eye infections Droopy eyelid

Other: _____

Do you wear glasses? No Yes: **How old is your present pair of glasses?** _____

Do you wear contacts? No Yes: **What type?** Hard Soft: **Brand?** _____

FAMILY HISTORY

Among your blood relatives, is there a history of any of the following? (circle) [**None]**

Glaucoma Lazy Eye Macular Disease Unexplained Vision Loss Eye Surgery

Cataracts Diabetes Retinal Disease Night/Color Blindness Bleeding Disorder

Other: _____

SOCIAL HISTORY

Do you use tobacco products?..... No Yes (how long) _____

Do you drink alcohol?..... No Yes (how long) _____

Do you use illegal drugs?..... No Yes (how long) _____

Have you been exposed to or infected with HIV?... No Yes (how long) _____

REVIEW OF SYSTEMS

Do you **currently** have any problems in the following areas? If "yes" then please provide information.

	No	Yes
Constitutional: Fever/Chills	_____	_____
Weight Loss/Gain	_____	_____
Skin: Rash	_____	_____
Neurologic: Headaches	_____	_____
Eyes: Loss of vision	_____	_____
Blurred/Distorted vision	_____	_____
Double vision	_____	_____
Dryness	_____	_____
Redness	_____	_____
Itching	_____	_____
Burning	_____	_____
Foreign body sensation	_____	_____
Excess tearing/watering	_____	_____
Mucous discharge	_____	_____
Glare/Light sensitivity	_____	_____
Eye pain or soreness	_____	_____
Chronic eyelid infection	_____	_____
Ears, Nose, Mouth, Throat: No Yes	_____	_____
Allergies/Hayfever	_____	_____
Sinus congestion	_____	_____
Dry throat/mouth	_____	_____
Respiratory: Asthma	_____	_____
Emphysema/Bronchitis	_____	_____
Cardiovascular: Chest pain	_____	_____
Irregular heart beat	_____	_____
GI: Stomach pain	_____	_____
Diarrhea/Constipation	_____	_____
Genitourinary: No Yes	_____	_____
Genitals/Kidney/Bladder ..	_____	_____
Bones, joints, muscles:		
Joint pain	_____	_____
Endocrine: Diabetes	_____	_____
High or low thyroid	_____	_____
Psychiatric:	_____	_____

Thank you very much for taking the time to fill out this lengthy health history questionnaire.
Our mission is to provide our patients with the most compassionate and highest quality healthcare possible.

Acknowledgement of Notice of Privacy Practices © POG 10-07

I hereby acknowledge that I understand this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the Reception Desk, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

For questions or concerns, please contact: Mary Ellen Bailey, OD
Privacy Officer, 650-697-3200.

In summary, this Notice:

- 1) outlines to whom we may legally disclose your health information, including your health insurance plan so we may obtain payment for our services
- 2) states that we will not disclose your health information in any other way without your written authorization
- 3) outlines your rights as a patient, including the
 - ◆ right to limit what information is disclosed
 - ◆ right to request confidential communication
 - ◆ right to inspect and copy your records
 - ◆ right to amend your records
 - ◆ right to receive a copy of the "Notice of Privacy Practices"
- 4) gives us the permission to change our "Notice of Privacy Practices" at any time in the future, at which point you will be notified again
- 5) informs you how to handle a complaint if you feel your privacy has been violated

Your signature on the form simply acknowledges that you understand our privacy practices.



Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient

Name of Patient: _____

 650.697.3200
 650.697.3203

Peninsula Ophthalmology Group
1720 El Camino Real, Suite 225
Burlingame, CA 94010-3224

PENINSULA OPHTHALMOLOGY GROUP OFFICE POLICY
UPDATED 1/1/2009

LATE ARRIVALS:

If you are more than 15 minutes late for your appointment time, we will try our best to fit your visit into the clinic schedule; however, there may be a wait since there may be other scheduled patients and we cannot guarantee that we will have sufficient time to complete your exam. We would be glad to reschedule your visit if you would prefer.

MISSED APPOINTMENTS:

We require a 24-hour notice of cancellations. Missed appointments are lost opportunities for other patients. There is a \$50 charge for appointments missed without 24-hour prior notice.

CO-PAYMENTS:

Insurance companies require us to collect your co-payment at the time of your visit. If you wish us to bill you for this co-payment, there will be an administrative charge of \$25.00.

RETURNED CHECKS:

Patients with checks returned for insufficient funds will be charged \$50.00 per check to cover bank fees.

OUTSTANDING BALANCES:

Balances outstanding beyond 30 days after the date billed are subject to interest at a rate of 1½% per month. Unpaid balances past 90 days are automatically sent to an outside collection agency.

CONTACT LENSES:

If you wear contact lenses, some or all of these services may not be covered by your insurance company. Details for fees and services are available on our *Contact Lens Information Sheet* which is available at the front desk.

I have been informed of the Peninsula Ophthalmology Group's Office Policy.

Patient Signature: _____

Date: _____

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