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CATARACT NEW PATIENT PACKET

Thank you for trusting Focal Point Vision with your eye care needs. We want you to be well-informed about your cataract surgery options before coming to your appointment and encourage you to visit our website at www.focalpointvision.com.

WHAT IS A CATARACT?

All of us are born with a flexible, clear lens in our eye called the "crystalline lens." As this lens becomes cloudy and less flexible, we call it a cataract. This lens is responsible for cloudy distance vision, occasional poor near vision, and problems with contrast and glare. During cataract surgery your surgeon will be replacing the natural cloudy lens with a clear artificial lens implant.

WHAT IS ASTIGMATISM?

It is a highly common condition that happens when the eye is shaped like a football instead of like a basketball. This can cause blurriness and double vision, as well as affect distance vision.

At Focal Point Vision our surgeons offer patients various options for their cataract surgery. For that reason, we invest and train our staff on different types of technologies that remove the cataract, and different types of implants that correct distance vision, astigmatism and improve near vision.

Cataract surgery has made amazing advancements. Traditionally, we have used ultrasound energy to remove cataracts. Today almost 50% of our cataract surgeries use LENSAR femtosecond laser to make incisions, correct astigmatism, and disassemble the cataract. This new technology allows more precise surgery and in most cases improved recovery.

FOCAL POINT VISION IS 1 OF 5 SITES IN THE US TO CURRENTLY OFFER PATIENTS THE EXCLUSIVE RXSIGHT LAL (LIGHT ADJUSTABLE LENS), THE FIRST CUSTOMIZABLE INTRAOCULAR LENS.

We one of only a few practices in central and south Texas to offer this technology to cataract patients. It allows our surgeons to customize and change your implant power after surgery.

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Below you will see your surgical options. It is important to remember that Medicare and commercial insurances typically cover the costs of cataract surgery because it is a medically necessary procedure. However, if you choose to undergo surgery with the LENSAR femtosecond laser and/or a specialized implant (or IOL), Medicare and commercial insurances consider these "non-covered services". This means it would be an out-of-pocket expense. Lastly, cataract surgery falls under medical insurance, not a vision plan or vision insurance. Vision insurances and vision plans are used to cover exams for glasses and contacts. Financing may be available. Please contact our business office to review your financial options.

BASIC CATARACT SURGERY PACKAGE 1

Basic cataract surgery is traditional cataract surgery designed for individuals who want to improved distance vision. Expectation for this package patient will need aid of glass for any astigmatism they may have and glasses for near vision.

CUSTOM LOW ASTIGMATISM PACKAGE 2

This is a laser cataract procedure with the use of LENSAR (femtosecond laser) and a standard intraocular lens implant. This will correct lower amount of astigmatism. It is designed for individuals who want good distance vision and correct lower levels of astigmatism.

CUSTOM HIGH ASTIGMATISM PACKAGE 3

This package is an advanced laser cataract procedure with the use of LENSAR (femtosecond laser) and a toric intraocular lens, which will correct higher amount of astigmatism. It is designed for individuals who want sharp distance vision with higher levels of astigmatism.

PREMIUM LIFESTYLE PACKAGES 4 AND 5

This is advanced laser cataract procedure with the use of LENSAR (femtosecond laser) and an advanced technology implant. Advanced implants will correct distance, astigmatism and improve near vision. It is designed for individuals who want the widest range of vision with improved near vision.

Our goal is to treat patients like family. We customize your treatment for your needs and lifestyle. Regardless of which option you and your doctor choose, you will get an excellent quality care. We look forward to meeting you at your consultation. (If you wear contact lenses please take them off a week before your appointment if possible)

Sincerely,
Kenneth Maverick, MD and James Lehmann, MD

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San Antonio, TX 78229

Focal Point Vision Alamo Heights
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San Antonio, TX 78209

Focal Point Vision Schertz
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INITIAL APPOINTMENT

Welcome to Focal Point Vision. You have chosen a leading eye care facility. Our goal is to make your experience here as pleasant as possible. You should plan to be here 1.5 to 2.5 hours, depending on the extent of your examination and any additional test, studies, or procedures that might be required.

Physicians: Our physicians are trained in the diagnosis and treatment of all eye diseases and are Board Certified with the American Board of Ophthalmology. Dr. Kenneth Maverick and Dr. James Lehmann are cornea specialists with a special interest in cataracts, corneal transplants, glaucoma and refractive services. Dr. Lee Peplinski, Dr. Jason Daughtry and Dr. Amy Conner are our Therapeutic Optometrists who coordinate your surgical plan with your surgeon and often provide postoperative follow up. They also specialize in the medical management of glaucoma and a variety of other ocular health conditions.

Please bring with you to your appointment:

- **Medications** - Please bring a current list of all the medication you are taking. You can also bring the medication in the bottles as received from the pharmacy if you wish.
- **Eyeglasses** - Please bring your best or most recent eyeglasses even if they no longer improve your vision. The glasses will provide important information about the past condition of your eyes.
- **Insurance Cards** - Please bring all current insurance cards with you to the appointment. We will bill your medical insurances, primary and secondary, for the medical eye exam and any additional tests, studies or procedures performed. Any unpaid visits due or invalid insurance cards will become the patient's (parent/guardian's) responsibility.
- **Photo ID** - We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

Insurance & Payment

- **Self-pay** - If you are not covered by medical insurance you will be expected to pay in full at the time of service.
- **Medicare** - We accept assignment on Medicare. If you do not have a secondary insurance you will be responsible for 20% of the Medicare allowed amount after the Medicare deductible has been met. Payment will be expected at the time of service.
- **Deductible** - Be prepared to pay your medical insurance deductible if it has not been met for the year.
- **Co-pay** - You are required to pay your insurance co-pay at the time of service. The co-pay amount is usually noted on your insurance card or can be found in your insurance handbook.
- **Payment options** - We accept cash, check, debit, Visa, MasterCard, American Express and Discover.
- **HMO/Managed Care** - If you are insured through an HMO or a Managed Care plan, you will need a referral authorization from your primary care physician before your appointment. Any unpaid visits due to an invalid or non-referral will become the patient's (parent/guardian's) responsibility.

Dilation: Your pupils will probably be dilated during the initial visit. Dilation lasts several hours and may blur your vision. You should bring a driver if you have not previously driven with dilated pupils.

General information: Office hours are Monday – Friday 7:30am – 4:30pm (except for holidays). We encourage you to call us anytime you have a question or problem with your eyes. Non-emergency calls are best handled during business hours. Emergency and after-hours calls are handled by our answering service or forwarded to the physician on-call.

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FINANCIAL POLICY

Thank you for choosing Focal Point Vision as your healthcare provider. We are committed to providing the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time.

INSURANCE POLICY: Your insurance is between you and the insurance company. Snip & Ference DBA Focal Point Vision's relationship is with you and not the insurance company. On the same note, we extend a courtesy to our patients and file your claims for you. However, all charges are your responsibility from the date services are provided. As with the case of all contracts, you the insured are expected to know your policy and its regulations as agreed upon by you and your insurance company at the time of enrollment. This will include referrals, second opinions or prior authorization. Our experienced staff will gladly assist you with obtaining any precertification or prior authorization as needed. However, in the event of failure to provide accurate up to date insurance information resulting in a denial and non-payment for services rendered, payment will be the responsibility of the patient or the insured. Additionally, we cannot guarantee that the information given to us by your carrier is correct. Our involvement will be limited to supplying factual information to facilitate claim processing. Out of pocket expenses such as deductibles, coinsurance and copayments are your responsibility to be paid at the time of service as stated in your contract with the insurance company.

OUT OF NETWORK: We accept a variety of insurance plans, and due to the complexity of managed care contracts (HMO's), we suggest patients to verify our doctor's participation of IN NETWORK STATUS with your insurance company prior to making the appointment at FOCAL POINT VISION.

In the event that the your insurance company does not cover certain tests like Scanning Computerized Ophthalmic Diagnostic Imaging (OCT), Corneal Topography or Visual Fields that our physicians would deem medically necessary in your care, you would be financially responsible for the cost of these tests.

SELF PAY: Payment is required to be paid at the time of service unless prior arrangements have been made with our billing department. Focal Point Vision gladly accepts cash, checks, Visa and MasterCard. There is a $25.00 returned check service charge.

REFERRALS: If you have an insurance that requires a referral. *It is your responsibility to obtain the referral from your primary care physician before your appointment.* Otherwise, the visit will not be covered by your insurance and you will be responsible for the payment. Please notify us if your insurance requires a pre-authorization for the office or outpatient procedures.

REFRACTIONS: Medicare and other health insurers will NOT pay for the glasses prescription. If you choose to have our doctor perform a refraction and provide you with an eyeglass prescription you must accept full financial responsibility for the cost of this service, the refraction fee is $75.00. The fee will be collected at the time of services and rendered.

Please note: All appointment cancellations and reschedules must be made at least 24 hours in advance. If you don't show to your appointment a charge of $25.00 will be added to your account.

I have read and fully understand and acknowledge the financial policy of Focal Point Vision. I acknowledge and agree to pay for any services and tests that are not covered by my insurance plan. Again, thank you for choosing Focal Point Vision as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Signature _____ Date _____

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OCULAR AND MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

PLEASE CHECK IF YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING:

Arthritis/Joint problems	Yes ☐ No ☐	Gout	Yes ☐ No ☐	Psychiatric problems/Depression	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Heart Disease/Attack	Yes ☐ No ☐	Sinus Problems/Allergies	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐	Herpes Simplex	Yes ☐ No ☐	Stroke or Neurological problems	Yes ☐ No ☐
Bronchitis/COPD/ Emphysema	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Chronic Headaches/ Migraines	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Chest Pain/Discomfort	Yes ☐ No ☐	Excessive bleeding with surgery	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Disabilities	Yes ☐ No ☐	Jaundice/Hepatitis	Yes ☐ No ☐	Unexplained Weight loss/gain	Yes ☐ No ☐
Dialysis	Yes ☐ No ☐	Kidney/Renal Problems	Yes ☐ No ☐	Insulin dependent?	Yes ☐ No ☐
Fever	Yes ☐ No ☐	HIV	Yes ☐ No ☐	Diabetes Type 1 ☐ 2 ☐	Yes ☐ No ☐
Gastritis/Reflux	Yes ☐ No ☐	Prostate Problems	Yes ☐ No ☐	Other (explain): _____	

PAST OCULAR HISTORY *Please check all that apply*

Cataracts	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Astigmatism	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Retinal Detachment	Yes ☐ No ☐	Myopia (near-sighted)	Yes ☐ No ☐
Diabetic Retinopathy	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐	Hyperopia (far-sighted)	Yes ☐ No ☐
Keratoconus	Yes ☐ No ☐	Eye Infections	Yes ☐ No ☐	Amblyopia (lazy eye)	Yes ☐ No ☐
Floaters	Yes ☐ No ☐	Corneal Ulcers	Yes ☐ No ☐	Eye Injuries	Yes ☐ No ☐

OCULAR SURGERIES/PROCEDURES *Please check all that apply*

Cataract Surgery	Yes ☐ No ☐	Retinal Laser Surgery	Yes ☐ No ☐	Lasik/PRK/RK	Yes ☐ No ☐
Corneal Transplant	Yes ☐ No ☐	Glaucoma Surgery	Yes ☐ No ☐	Other (explain) : _____	

FAMILY HISTORY *Please check all that apply*

Blindness	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Fuch's Dystrophy	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Retinal Detachment	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐	Corneal Transplant	Yes ☐ No ☐

SOCIAL HISTORY *Please check all that apply*

Alcohol Use	Yes ☐ No ☐	Able to read English	Yes ☐ No ☐	Drives Motor Vehicle	Yes ☐ No ☐
Do You Smoke?	Yes ☐ No ☐	How often? _____			
Have you ever smoked?	Yes ☐ No ☐	When did you quit? _____			

Form completed by: _____ Relationship: _____ Patient Signature: _____

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CURRENT MEDICATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

PLEASE LIST ALL MEDICATIONS, VITAMINS, EYE DROPS, OR SUPPLEMENTS THAT YOU ARE **CURRENTLY** TAKING:

Drug name	Dosage	How often?

PHARMACY INFORMATION:

Pharmacy name: _____ ☐ Local ☐ Mail Order

Address: _____

Have you ever used the following:? (Only check if **YES**)

☐ Flomax (Tamsulosin) ☐ Avodart (Dutasteride) ☐ Alfuzosin (Uroxatral) ☐ Proscar (Finasteride)

DRUG ALLERGIES

Drug name	Reaction

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LIFESTYLE VISION QUESTIONNAIRE

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis.
Along with your exam, this information will assist us in recommending the best option for your eyes and your personal lifestyle.

Do you wear glasses now?
Yes ☐ No ☐

If yes, how frequently?
☐ All the time ☐ Sometimes ☐ Only for distance ☐ Only for reading ☐ Only for the computer

If yes, how do you feel about wearing glasses?

____

If it were possible to go without glasses most of the time, would you like that? Yes ☐ No ☐

What type of visual outcome would you like after cataract surgery? (Check all that apply)
☐ Reduce need for glasses ☐ Reduces my prescription
☐ See better than I did before surgery ☐ I didn't realize there were options

Check the following activities you do on a regular basis and underline the activities you would like to do without glasses, if possible.

☐ Read newspapers/books	☐ Play tennis	☐ Golf
☐ Hunt or fish	☐ Use call phone	☐ Read medicine bottles
☐ Paint/draw	☐ Watch movies in theatre	☐ Needlepoint/sew
☐ Watch spectator sports	☐ Photography	☐ Crossword puzzles
☐ Cook	☐ Participate in water sports	☐ Visit/care for grandkids
☐ Drive in the daytime	☐ Drive in the nighttime	☐ Use the computer
☐ Other (please list)		

____

How important is it for you to read or use the computer without glasses?
☐ Very Important ☐ Important ☐ Not Important

Please place an "X" on the following scale to describe your personality as best you can:

Easy going ... ... Perfectionist

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PATIENT INFORMATION

THE PATIENT

First name: _____ Last name: _____ Date of birth: _____
Address: _____ City: _____ State and zip: _____
SSN: _____ Gender: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow
Home phone: _____ Cell phone: _____ Email Address: _____
Employer: _____ Occupation: _____ Work Phone: _____
Emergency contact : _____ Phone: _____ Relationship: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Caucasian
☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other (please list): _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Preference of appointment reminder: ☐ Phone ☐ Text ☐ Email: _____

How did you hear about us? ☐ Internet ☐ Friend ☐ Other: _____ ☐ Dr. _____

Primary Insurance:
ID #: _____
Group #: _____ Ph: _____
Subscriber's Name: _____ DOB: _____
Relation to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance:
ID #: _____
Group #: _____ Ph: _____
Subscriber's Name: _____ DOB: _____
Relation to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Primary Care Physician: _____ Phone: _____
Referring Eye Care Provider: _____ Phone: _____

Do you have a health care proxy (medical power of attorney)? Yes ☐ No ☐ **If so, please complete the following:**
Do you have an Advanced Care Directive? Yes ☐ No ☐

THE RESPONSIBLE PARTY

If someone other than the patient is responsible for this account please provide their information.

First name: _____ Last name: _____ Date of birth: _____
Address: _____ City: _____ State and zip: _____
Home #: _____ Cell #: _____ Email address: _____

I hereby authorize my insurance company to pay directly to Focal Point Vision Correction, all benefits otherwise payable to me under the provisions of my policy. I hereby authorize the necessary medical information to be released to the insurance company for processing this claim and to be released to physicians or optometrists in connection with the continuity of care of patient. Photostat copies of this authorization will be considered as valid as the original.

Form completed by: _____ Relationship: _____ Patient's Signature: _____

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MEDICAL NECESSITY

Patient name: _____ Surgeon: _____OD/OS Date: _____

DO YOU HAVE DIFFICULTY (EVEN WITH GLASSES) WITH THE FOLLOWING?

Reading small print such as labels on medicine bottles, a telephone book or food labels?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Reading a newspaper or book?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Seeing steps, stairs or curbs?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Reading traffic signs, street signs or store signs?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Doing fine handwork like sewing, knitting, crocheting or carpentry?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Writing checks or filling out forms?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Playing games such as bingo, dominos, card games or mahjong?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Watching television?
☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?
☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Do you have difficulty with glare, such as trouble driving at night?
☐ Yes ☐ No ☐ Not Applicable

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign
☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
☐ We weren't able to communicate with the patient.
☐ Other (Please provide specific details): _____

_____ _____

Employee Signature Date

2020 HIPAA Acknowledgement of receipt of the Notice of Privacy Practices. This form does not constitute legal advice and covers only federal, not state law.

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ELECTRONIC PRESCRIBING CONSENT

Patient name _____ DOB _____

The providers at Focal Point Vision use an electronic medical record system (EMR) that permits our providers to prescribe medications electronically. The capability is known as **E-Prescribing** and is defined as a physician's ability to electronically send an accurate and understandable presciption directly to the pharmacy from the point of care. Congress has determined that the ability to send presciptions electronically is an important element in improving the quality of patient care. This process helps reduce medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program.

These include:

Formulary and Benefit Transactions
Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication History Transactions
Provides the physician with information about medications that the patient is already taking to minimize the number of adverse drug events.

Fill Status Notification
Allows the prescriber to receive an electronic notice from the pharmacy notifying them if the patient's prescription has been picked up, or partially filled.

By signing this consent form you are agreeing that Focal Point Vision can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Focal Point Vision to enroll me in the E-Prescribing Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

☐ Accept ☐ Decline

Patient name _____ DOB _____

Signature of patient _____ Date _____