Kim L. Cooper, MD

A Professional Corporation

Pediatric Ophthalmology
&
Strabismus

American Academy of Ophthalmology
Fellow, American Academy of Pediatrics
American Association of Pediatric Ophthalmology & Strabismus
Diplomate, American Board of Ophthalmology

Date ____________________

Dear Patient/Parent,

Welcome! Thank you for choosing our practice. Our goal is to provide our patients with the highest quality ophthalmic care in a compassionate patient focused environment.

PLEASE HAVE YOU/YOUR CHILD ARRIVE AT ____.

You/your child have an appointment on __________ at _________ with ______________________________.

Prior to your appointment please complete the enclosed registration and history forms and remember to bring your insurance card(s), co-payments and all necessary authorizations to your appointment**.**
All new patients are asked to arrive 30 minutes early to allow time to process your registration forms.

Please avoid bringing ill siblings or friends to the office and if your child has a cold or an illness, please call us to reschedule

To Reschedule or Cancel Appointments please call 2 business days prior to your appointment so that our patients who have been waiting for an appointment can be seen.

Missed Appointments and Late Cancellations (A late cancellation is less than 2 business days advanced notice)
You must cancel or reschedule your appointment more than 2 business days prior to your appointment or you will be charged $100.00 for each missed appointment. If multiple appointments are booked for your family members on the same day and you do not call 2 business days prior to their appointment to cancel or reschedule you will be charged $100.00 per family member.

This initial examination will take approximately 2 hours. Follow-up visits require 30 minutes to 1 hour. Eye drops are required on the first visit for a complete medical eye examination and refraction. Refraction is a test done to determine the best possible vision and whether medical, optical, or surgical interventions are necessary. This is a very important part of a complete eye examination, especially in children less than 5 years old who may have amblyopia (lazy eye) or strabismus (crossed eyes). The dilating drops will temporarily blur your child's vision for 4 to 12 hours. Please plan to avoid near tasks, like reading, immediately after this appointment. Please bring your sunglasses. If you/your child have seen previous eye doctors, we request that you send a copy of those records to our office (address and fax below) or bring them with you to the appointment. If your child wears glasses or contacts, please bring them to the appointment and fill out the enclosed contact lens questionnaire. Refractions are usually not a covered medical service, but sometimes may be reimbursed by medical insurance plans for children less than 18 years of age. Refractions may be covered by vision insurance plans. We will be happy to submit claims to your primary medical insurance and/or vision plan at the time of your visit, but we cannot retroactively bill your vision insurance. If our services are not covered by your medical insurance, we request payment in full at the time of service. **If deductibles or co-payments are necessary, they are due and payable at the time of service. For your convenience we accept cash, personal checks, and MasterCard and Visa.**

We encourage you to be involved in your child's health care by asking questions and/or providing information you consider important. All information is confidential and available only to patients, parents or legal guardians. To facilitate treatment and improve communication, we ask that a parent, or legal guardian accompany each child under age 18 to each appointment. If this is not possible, please send a signed letter authorizing us to see you or your child with another designated adult. Please confirm that you have completed the ***Patient Confidentiality Agreement*** portion of the *Patient Information Form* (yellow) you received. Your signature gives us permission to discuss you and/or your child's medical conditions with the people you have listed, as well as your doctors.

We look forward to meeting you and your child. We strive to provide excellent care in a friendly environment.

Sincerely,
Kim L. Cooper, MD
Rupali Apte, MD

v.102417

1720 El Camino Real, Suite 235, Burlingame, CA 94010 • Tel: 650-259-0300 • Fax: 650-259-0505

American Association for Pediatric Ophthalmology and Strabismus

REFRACTION POLICY STATEMENT

Amended, October 21, 2000
Amended, April 12, 2000
Approved, October 23, 1999

REFRACTIONS IN CHILDREN

Childhood Eye disorders require a thorough medical evaluation. Additional diagnostic testing, such as refraction, is required. Refraction is the determination of the optical properties of the eyes.

Refraction is needed to properly diagnose and effectively treat many causes of lazy eye (amblyopia), or misalignment of the eyes (strabismus). If undetected, these conditions may lead to permanent loss of vision.

Refraction (*92015) is a medical necessity and is not included as a work component of any other * CPT code and should be reimbursed separately.

*92015 is the billing CPT code for refraction
Current Procedural Terminology or CPT codes are the numerical codes used to report medical, surgical, and diagnostic procedures and services to health insurance companies.

AMBLYOPIA POLICY STATEMENT

Amblyopia is a Medical Condition

A Joint Statement of the American Association for Pediatric Ophthalmology and Strabismus and the American Academy of Ophthalmology

Policy

Amblyopia is a medical condition which requires medical treatment

Amblyopia is typically a preventable and treatable form of vision loss. Unless amblyopia is treated promptly during childhood, structural changes occur in the brain of the amblyopic child, resulting in decreased visual function.
Optical correction such as eyeglasses or contact lenses may be medically indicated as a part of amblyopia treatment in addition to other modalities, such as patching and/or pharmacologic treatment. Unless amblyopia is treated during childhood, vision loss is likely to be irreversible.

American Academy of Ophthalmology
Board of Trustees, August 2006
Approved by: **American Association for Pediatric Ophthalmology and Strabismus**
Board of Directors, November 11, 2006

v.062017

1720 El Camino Real, Suite 235, Burlingame, CA 94010 • Tel: 650-259-0300 • Fax: 650-259-0505

Kim Cooper MD 1720 El Camino Real, Suite 235 Burlingame CA 94010

Welcome to our office. Please fill out both sides of this form. Thank you.

Appointment Date:				
Patient's Last Name	Patient First Name	MI	Nickname	Sex: ☐ Male ☐ Female
Date of Birth	Age	Patient's Social Security #		

Primary Care Dr Name		Phone #
Street address:	City/State	Zip:

Guarantor Information

Please provide information for: ☐ Yourself ☐ Both parents ☐ the child's Legal Guardian (LG)

Last Name **Self, Father, LG**	First	MI	Social Security #
Address	City	State	Zip
Cell Phone	Email	Home Phone	
Employer Name	Occupation	**Work Phone**	Ext:

Last Name **Mother, Father, LG**	First	MI	Social Security #
Address	City	State	Zip
Cell Phone	Email	Home phone	
Employer Name	Occupation	Work Phone	Ext:

In an emergency, apart from immediate family, who may we contact?	NAME:		Relationship to patient
City	State	Zip Code	Phone # Phone # 2

Please list your Health Insurance Information

Primary	Secondary
Health Insurance	Health Insurance
ID# Group #	ID# Group #
Name of Insured	Name of Insured
Social Security # Date of Birth	Social Security # Date of Birth
Whose policy is this? Self Spouse Mother Father Guardian	Whose policy is this? Self Spouse Mother Father Guardian

Please list your Vision Insurance Information

Primary	Secondary
Name	Name
ID# Group #	ID# Group #
Name of Insured Person	Name of Insured Person
Social Security # Date of Birth	Social Security # Date of Birth
Whose policy is this? Self Spouse Mother Father Guardian	Whose policy is this? Self Spouse Mother Father Guardian

Medicare patients must sign lifetime beneficiary claim authorizations. I request that payment of authorized Medicare benefits be made to Kim Cooper MD on my behalf for any services furnished me by Dr Cooper or her employees. I authorize any holder of health information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I authorize release of information necessary to pay the claim. If other insurance information is indicated in item 9 of electronically submitted claims; my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier.

_______________________________________ ____________________

Signature of Medicare Patients Date

Policy Rules and Procedures

Health Insurance Coverage

I consent to necessary medical care and treatment by Kim Cooper MD. I ______________________ have health insurance coverage with the insurance company (see page one) and assign directly to Kim Cooper, MD all surgical and or medical benefits, if any, otherwise payable to me for services rendered. I authorize the doctor to release all information necessary to secure the payment of benefits. I am financially responsible for all charges whether or not paid by insurance.

Prior written authorizations:

If my plan requires one, and I agree to see the doctor without prior written authorization I will be fully responsible for the charges not paid by insurance.

Returned checks: I will be charged $25 for each check returned by the bank.

All co-payments are collected at the time of service. If I fail to pay my co-payment I will be charged an additional $35 to send me a bill for a co-payment.

All unpaid balances over 30 days are subject to a rebilling charge of $35 (*Bank fees and rebilling charges are subject to change at any time.)

Late Cancellations and Missed Appointments

If I do not call 2 business days prior to my appointment to cancel or reschedule I will be charged a fee for the Missed Appointment/Late Cancellation and If I, parent or legal guardian, have booked multiple appointments for my children on the same day and I do not call 2 business days prior to my appointment to cancel or reschedule I agree to pay the Missed Appointment/Late Cancellation fee for each child. Please initial: ☐

Amblyopia diagnosis

I understand that services with a diagnosis of amblyopia may not be a covered benefit of my health plan and I am responsible for these charges

Refractions

I understand that the *refraction* portion of the eye exam may not be a covered benefit of my health plan and I am responsible for this charge.

Contact Lenses

I understand that if I am a new contact lens user, my prescription will be released when the 90 days of follow up care is complete.

I have read, understand and agree to the policy rules and procedures as written above

_______________________________________ ____________________

Signature of patient or parent if patient is a minor Date

Patient Confidentiality Agreement

My signature below confirms that I am the person legally responsible for the patient and I consent to necessary medical care and treatment of the patient. I will notify you of any changes in the information or of any change in the patient's health status.

_______________________________________ ____________________

Signature of parent or legal guardian Date

I, ____________________, patient/mother/father/legal guardian give permission for Kim Cooper MD and/or her staff to release confidential medical information regarding **me or my child**, ________________________to the persons listed below:

Name		Date of Birth	SSN (last 4)
Mother's Name:	Phone #		XXX-XX-
Father's Name:	Phone #		XXX-XX-
Other Name:	**Relationship**	Phone #	

This consent/release remains in effect until I present a ***written*** request for changes.

_______________________________________ ____________________

Signature (patient/mother/father/legal guardian) Date

Date:	Allergies to medication/food/latex? Reactions? □NKDA	Consult requested by/PCP/Ophthalmologist/Optom

Patient's Name:	Age: Mo Yr.	Date of birth:	☐Male ☐Female	Parents name/s (if pt is minor): H Phone: Occupation:

Please give a brief description of the reason for this visit. (loc/qual/sev/dur/time/context/mod fac/assoc s/s)

Is there a history in □mom's □dad's family of crossed eye / crooked eye / lazy eye / patching as a kid / eye muscle surgery / wearing glasses at age 2-3 years? Y / N

Seen with / hx obtained from: Mother Father Grandmother Grandfather Other (need permission slip):___________

Patient eye History:	Has worn glasses Years	Has worn contacts Years (Please fill out Contact Lens Questionnaire)

Eye medications: □none	Date of last eye exam:	Previous eye doctor:
	Eye surgery/laser history (Procedure /date):	

Past surgeries (procedure/date):

Glasses for: ☐Mom at age____ Rx:_____________
☐Dad at age_____ Rx:_____________

Would you like information on contact lens, cataract surgery, or LASIK? Y/ N

Patient Birth History: lbs oz. Duration of pregnancy: weeks Premature? Y/N Twins? Y/N Adopted? Y/N

Complication of pregnancy/birth: Were fertility drugs used during pregnancy? Y/N

Patient Medical History: Have you had problems with the following?

Are you currently pregnant? Yes No
Due Date:

yes	no	
		Color vision problems
		Drifting/crossed eyes
		Shaky eyes/nystagmus
		Double vision R/L/both
		Head tilt/turn
		Sees black spots (floaters)
		Flashing lights
		Light sensitive
		Difficulty seeing
		Squints
		Blurred vision R/L/both
		Sits near TV
		Eye strain R/L/both
		Eye pain R/L/both
		Discharge R/L/both
		Blinking a lot
		Red eyes R/L/both
		Rubs Eyes
		Itchy eyes R/L/both
		Tearing R/L/both
		Eye trauma R/L/both
		Glaucoma R/L/both
		Cataracts R/L/both
		Abnormal pupil R/L/both

yes	no	
		Seizures
		Diabetes: on insulin/pills
		Low or High blood pressure
		Thyroid disease
		Asthma/emphysema/breathing
		Arthritis/JRA/Joints
		Heart problems
		Cancer/Type
		Psychiatric problems
		HIV/TB/Hepatitis A B C
		High cholesterol
		Ears
		Nose
		Throat
		Intestine/stomach/feeding
		Urinary tract/kidney
		Reproductive
		Skin
		Bleeding tendency
		Neurological/Stroke
		Headache/migraine
		Developmental delay
		Problem with motor/speech
		Down's Syndrome
		ADD/ADHD/autism
		Hay fever/allergies
		Problems with anesthesia
		Reading issues/dyslexia
		Other:

Systemic Medications- (aspirin, Motrin, Vioxx, birth control, vitamins, herbal meds)
Please list: / /

Immunization- □up to date □delinquent □had smallpox vaccine/date

Patient Family History:

yes	no	
		Strabismus (crossed eyes)
		Amblyopia (lazy eye)
		Far or near sighted
		Cataract
		Glaucoma
		Blindness
		Retinal problems
		Color vision problems
		Other eye conditions
		Diabetes
		Hypertension
		Heart disease
		Cancer
		Problems w/anesthesia

Other:

Patient Social History:

		Tobacco: pp day #yrs
		Alcohol: drinks/day
		Drugs:

Children/sibs-name/age:

Ethnicity:

African Am		Asian		Hawaiian	
Hispanic		E Indian		Multi	
Pac Isl		White		Other	
KC, MD		DN, OD		LH, OD	
RA, MD		JL, OD		EMR, OD	
AR, OA		AA, OD		GM, OA	

KIM L COOPER, MD	BURLINGAME, CA

Patient Summary Sheet

Patient name:	Consult requested by: Dr City:
Drug allergies / reactions:	Referred by: □ Dr □ Friend □ Relative □ Other
☐ NKDA	Primary Care Dr: City:
Major/Chronic problems:	Names of *patient's other doctors*/specialists:
	1. Ob/Gyn: 6. Other Ophthalmologists:
	2. Cardiologist: 7. Optometrist:
	3. Neurologist: 8. BBF nurse:
	4. Rheumatologist: 9.
FHx:	5. Endocrinologist: 10.

CURRENT PROBLEMS (OFFICE USE ONLY)

Date	ICD-9	Procedure / Problem □entered in IP list date:
	□ Old records reviewed. Dr:________________	

Date	Missed appointments	Date	Doctor' s notes:
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to:	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to:	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to:	
	□CE □OV □OT □CTL □_______ Reason:	□LM to res □Resch'd to:	

Kim L. Cooper, MD
A Professional Corporation

Pediatric Ophthalmology
Strabismus &
Family Eye Care

American Academy of Ophthalmology
Fellow, American Academy of Pediatrics
American Association of Pediatric Ophthalmology & Strabismus
Diplomate, American Board of Ophthalmology

Refractions

Refraction is done to determine whether you are nearsighted, farsighted, have astigmatism and whether glasses are necessary or need to be changed. This is a very important part of a complete eye examination, especially in children who may have amblyopia (lazy eye), strabismus (crossed eyes), who are less than 5 years old, or have failed a vision screening examination. Most importantly, it will determine how well you can see. If your vision cannot be corrected with glasses, you may have some form of eye disease.

Although we feel a refraction is important, *many* medical insurance companies do not pay for this service. Some medical insurance plans cover refractions for children under age 18; however, you should contact your plan for specific information. Our charge for a refraction is $70.00, if you have a vision insurance plan, such as Vision Service Plan (VSP), EyeMed or Medical Eye Services (MES), most of this charge may be covered. Vision insurance is designed to cover routine eye examinations for refractive errors (nearsighted-myopia, far sighted-hyperopia, astigmatism, or presbyopia-reading glasses over age 40). Medical insurance will cover the portion of the eye exam that is not routine and may include medical eye conditions such as amblyopia, strabismus, cataracts, glaucoma, etc.

It may be possible for us to perform an eye examination in order to be sure you have no serious eye disease without performing a refraction. Ideally, a complete eye examination *should* include a refraction, especially if you cannot see well. Because we do not wish to present you with any unexpected charges, we will only perform a refraction with your permission.

Please let us know what you would like to do today.

- ☐ I **do** wish to have a refraction performed; I understand that I am responsible for services provided which may be denied by my insurance.
- ☐ I **do not** wish to have a refraction performed.
- ☐ I wish to discuss with doctor

Patient's Name (please print)	Patient/Parent's Signature	Date

(please turn over)

v.062017

1720 El Camino Real, Suite 235, Burlingame, CA 94010 • Tel: 650-259-0300 • Fax: 650-259-0505

Kim L. Cooper, MD
A Professional Corporation

Pediatric Ophthalmology
Strabismus &
Family Eye Care

American Academy of Ophthalmology
Fellow, American Academy of Pediatrics
American Association of Pediatric Ophthalmology & Strabismus
Diplomate, American Board of Ophthalmology

Office Policy Statement on Amblyopia Diagnosis and Your Insurance

Amblyopia is a medical condition which requires medical treatment. Amblyopia is typically a preventable and treatable form of vision loss. Unless amblyopia is treated promptly during childhood, structural changes occur in the brain of the amblyopic child, resulting in decreased visual function. Optical correction such as eyeglasses or contact lenses may be medically indicated as a part of amblyopia treatment in addition to other modalities, such as patching and/or pharmacologic treatment. Unless amblyopia is treated during childhood, vision loss is likely to be irreversible.

Because many insurance carriers have begun to deny benefits for Amblyopia, you may get a bill from our office. As always, we will continue to bill your insurance for these services. However, if you receive a statement from our billing department requesting payment, please contact your insurance carrier. They will assist you to with any questions that you may have regarding your responsibility.

I have read and understand that I am financially responsible if my insurance carrier denies payment for this service.

____________________________	____________________________	__________
Patient's Name	Patient/Parent Signature	Date

Patient/Parent/Guarantor:
☐ has declined to sign
☐ wishes to discuss with doctor

initial _____

v.062017

1720 El Camino Real, Suite 235, Burlingame, CA 94010 • Tel: 650-259-0300 • Fax: 650-259-0505