BLISS EYE ASSOCIATES

ABOUT OUR PRACTICE

MATIN KHOSHNEVIS, M.D. has treated thousands of patients for eye disease and has performed thousands of ophthalmic surgeries. Dr. Khoshnevis grew up in Orange County. He attended the University of California, Irvine where he first attained his Bachelor of Science with honors in Biological Sciences, then completed Medical School. During Medical School, he conducted research with the world-renowned neuro-ophthalmologist Alfredo A. Sadun at the University of California, Los Angeles (UCLA). He was awarded the United Mitochondrial Disease Foundation student fellowship award for his work on Leber's Hereditary Optic Neuropathy, a rare genetic eye disease.

This highly prestigious award is given to only one person in the country per year. Dr. Khoshnevis graduated Medical School with a distinguished diploma. He was awarded the Meyskens Clinical Research award which is given to one graduating senior exhibiting the highest potential for a career in clinical research, publication, innovation, and academic standing. He subsequently completed a preliminary intern year in Internal Medicine at UCLA Harbor. During his intern year, he patented a new type of ocular prosthesis with a more authentic eye motility and pupil mimicry, leading to founding his company, 3D-Optix. Dr. Khoshnevis completed his Ophthalmology residency at Temple University, continuing to be prolific authoring papers and textbook chapters.

His areas of expertise include state-of-the-art cataract surgery, laser vision correction surgery, as well as the medical and surgical management of glaucoma. Dr. Khoshnevis specializes in multifocal lens implantation and astigmatism correction. He has studied surgical advances extensively throughout the world and strives to offer his patients the very finest technology available.

REBECCA KENNEDY, O.D. received her training at the New England College of Optometry in Boston, Massachusetts. Her undergraduate work was completed at the University of Washington, Seattle. She is therapeutics and glaucoma certified and has an American Board Certification in Medical Optometry. Dr. Kennedy provides a full range of optometric services that include expertise in contact lens fitting, pre-operative and post-operative care, and annual eye examinations.

STEPHANIE YOSHIMURA, O.D. graduated from the University of California, Berkeley School of Optometry in 2003. Her undergraduate work was done at the University of California, Davis in 1998. Dr. Yoshimura has an American Board Certification in Medical Optometry. Dr Yoshimura is well versed in the areas of laser vision correction (LASIK), pre and post-operative care for cataract surgery, comprehensive eye care and is certified to treat primary open angle glaucoma.

JUSTIN KOZLOSKI, O.D. obtained a Bachelors of Science in Chemistry with a minor in Biology from The University of the Pacific in Stockton, CA. Dr. Kozloski went on to receive his doctorate in Optometry at the Midwestern University Arizona College of Optometry. Dr. Kozloski's desire to best serve his patients led him to take a residency in Low Vision Rehabilitation at The University of the Incarnate Word in San Antonio, TX. Shortly after residency, Dr. Kozloski was awarded his fellowship with the American Academy of Optometry (F.A.A.O.). Dr. Kozloski is board certified in the use of therapeutics and certified in the optometric treatment of glaucoma and ocular disease.

BLISS EYE ASSOCIATES
5773 Greenback Lane
Sacramento CA 95841
(916) 863-3143 blisseye@blisseye.com www.blisseye.com

OUR STAFF: Our office is staffed with certified ophthalmic assistants and experienced support personnel who are here to assist you.

Appointments & General Information:	(916) 863-3143
Billing Department:	(916) 863-2613
Surgical Coordinator:	(916) 863-2616
Optical Department:	(916) 863-2612
Practice Administrator	(916) 863-2614

Send general questions that do not include personal healthcare information to blisseye@blisseye.com

OFFICE HOURS: We are open Monday - Friday from 8:00 am - 5:00 pm. There is an ophthalmologist on call 24 hours per day 7 days a week in case of an emergency.

INSURANCE BILLING: We contract with a broad variety of medical insurance companies, HMO's, PPO's, medical groups and vision plans. We are happy to bill your insurance. Due to the complexity of the ever changing insurance industry, ultimately, it is your responsibility to understand your coverage (deductible amount, exclusions, co-payment and co-insurance).

FINANCING PLANS: We offer financing for patients who prefer to make affordable monthly payments for services, surgeries, and eye wear that are not covered by your insurance. Our staff will be happy to assist you with this simple process.

MEDICAL, SURGICAL, AND WELL EYE CARE

We provide a broad variety of eye care services, including medical and surgical treatment of eye disease, elective vision correction procedures, well eye care, and optical goods.

LASER VISION CORRECTION: Bliss Eye Associates is dedicated to advancing the state of the art of Laser Refractive Surgery. We constantly search for the best instrumentation and techniques available for the treatment of your eyes. Dr. Khoshnevis was a pioneer in bringing advanced techniques such as LASIK to Northern California. Laser vision correction is an affordable, painless procedure that can simplify and enhance your lifestyle. Treatment is currently available for patients who are nearsighted, farsighted, or have astigmatism. If you would like to reduce your dependence on glasses or contact lenses, we can help. We offer free screenings for interested patients.

CATARACT SURGERY: Bliss Eye Associates goal is to provide our cataract patients with the safest, most pain-free recovery of vision possible. For many years we have implemented and improved upon micro incisional sutureless surgery. We specialize in techniques that allow some cataract surgery patients to reduce, or even eliminate, the need for glasses. We are proud to make available breakthrough implant technologies that offer patients more options than ever before. The FDA has approved astigmatism-correcting implants and bifocal/multifocal implant lenses which can provide patients with significantly more comfortable unaided vision following cataract surgery.

The bifocal/multifocal implant lens takes the prescription power you currently have in your bifocals or reading glasses and allows us to place it directly into the eye at the time of cataract surgery. This means many of our patients actually have better unaided vision following cataract surgery than they did in their twenties and thirties.

COMMUNITY EDUCATION

The doctors of Bliss Eye Associates greatly enjoy educating the community about recent advances in micro laser technology, state-of-the-art cataract surgery techniques, laser vision correction, and advanced multifocal technologies. If you would like to schedule one of our doctors to conduct a free multimedia seminar for your group, please contact our administrator.

VISIT OUR WEB SITE

We invite you to visit our web site at www.blisseye.com for additional information on laser vision correction and treatment of cataracts. **Follow us on Instagram @blisseyeassociates**

PLEASE READ/ SIGN THE FOLLOWING DOCUMENTS AND BRING THEM TO YOUR APPOINTMENT

OPTICAL FINANCIAL POLICIES

We are always concerned with the health and safety of your eyes. **Contact lenses** are a good solution for many patients, but the process takes additional time and commitment on your part and ours. Contact lens services are not included in the standard exam fee/refraction fee. Fees will be dependent upon the level of service necessary to provide you with the proper lenses for your personal situation. There will be an additional fee for the contact lenses themselves. A full listing of our contact lens pricing structure is available at your request. There is a fee for a contact lens evaluation in a patient currently wearing contact lenses. This fee will be collected at the time of service.

The part of an eye examination that determines your eyeglass or contact lens prescription is called refraction. **Refraction** is done under certain circumstances for diagnostic purposes. REFRACTION IS NOT COVERED BY MEDICARE OR MOST INSURANCE PLANS, even when the doctor feels that it is necessary for diagnostic purposes. The fee for refraction is collected at the time of service.
I understand that I am personally responsible for payment of fees for refraction and contact lens service if they are not covered by my insurance plan.

Frames generally come with a 1-year manufacturer's warranty for manufacturer's defects. If your frame breaks under normal wear and tear with no apparent abuse, it will be warranted.

Lenses with scratch resistant coatings, anti-reflective coatings, polycarbonate, Trivex®, hi-index, progressive or Transitions are covered for a 1-year scratch resistant warranty, as long as the lens has normal wear and tear with no apparent abuse.
Progressive lenses are covered under a 60-day non-adaptation warranty. If you are unable to adapt to progressive lenses within 60 days, we will remake your lenses into single vision, lined bifocal or trifocal lenses at no additional cost to you. No refund will be given for the difference in price between these lenses.

If however, you feel that there has been an error in your prescription, the prescribing doctor should see you to verify that prescription. If the doctor makes changes to the prescription and requires the glasses to be remade, the lenses will be remade at no charge. After 60 days however, there will be charges associated with office visits and any lens changes. If your prescription was filled outside our office, please check their policies as we will not be responsible for any charges incurred.

Your prescription glasses are custom made and are therefore not returnable. No refunds or insurance reversals will be given for any order. If you cancel your order before the lenses are processed, you will receive a 90% refund and a 10% processing fee will be charged.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits for any service furnished to me by Matin Khoshnevis, M.D., Inc., or any of his employed associate doctors be made to Matin Khoshnevis, M.D., Inc., I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance or non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier, and are due at the time of service.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

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BLISS EYE ASSOCIATES

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits be paid directly to the physician. I understand that the insurance is a method of reimbursing the patient for fees owed to the physician and is not a substitute for payment. It is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid to the physician by my insurance. I also authorize the physician to release any information required to process an insurance claim.

PAYMENT AGREEMENT

It is our policy to collect at the time of service for all co-payments and services that are not covered by your insurance carrier. If you arrive for your appointment unprepared to make any payment due, your account will assessed a $10 service charge for each bill that is generated. If you are able to make the payment prior to the billing cycle, no fee will be assessed.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

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BLISS EYE ASSOCIATES

PATIENT CONFIDENTIALITY PROTOCOL

Purpose: To preserve and protect the privacy and confidentiality of all patient healthcare information and to prevent civil or prosecution for illegal disclosure of such information.

Policy: It is the policy of this office to ensure that all healthcare information of all patients is kept confidential.

General Information: It is the right of all patients to receive full consideration of privacy and confidentiality with regard to all information and records about their care. Health plans and reviewers acting as agents, however, do have certain rights of access to patient medical information for quality-of-care purposes.

Responsibility: This office maintains confidentiality of patient information.

Procedure:

1. All employees, contractors, consultants, and anyone who may have access to Individually Identifiable Health Information (IIHI) will sign a statement not to disclose or release confidential information for any reason not medically indicated to any persons other than those legally authorized to receive same.
2. Except when required in the regular course of business, the discussion, use, transmission, or narration, in any form, of any member information, which is obtained in the regular course of job functions, is strictly forbidden.
3. Temporary placement of member records in unattended areas should be avoided and all records are to be maintained in secured files and in a manner that allows access to authorized individuals only.
4. Facsimile transmission of member data should be limited to documents necessary for the purpose of completing a transaction or communicating specific member data to an authorized individual to whom it is addressed.
5. Electronic access to member data should be password protected to limit data retrieval to what is needed for job functions

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

BLISS EYE ASSOCIATES

PATIENT REGISTRATION FORM

Date:_____ Your Date of Birth:_____ Your Gender: MALE FEMALE

Patient Name (first/middle/last)_____

Mailing Address:_____ _____

Social Security Number:_____ Driver License Number:_____

Who is your Doctor at Bliss Eye Associates? (circle one) KHOSHNEVIS KENNEDY YOSHIMURA KOZLOSKI

Did a patient refer you? NO YES Name of Patient who referred you:_____

How did you hear of our office?_____

Did a Doctor refer you? NO YES Name of Doctor who referred you:_____

Do you have an Optometrist (outside of Bliss Eye Assoc.)? NO YES Optometrist Name:_____

Do you have a Primary Care Doctor? NO YES PCP Name:_____

Home Phone Number:_____ Work Phone Number:_____

Cellular Phone:_____ Best Daytime Phone Number HOME WORK CELLULAR

Your E-Mail Address:_____Do you wear glasses?_____ Do you wear contact lenses?_____

Employer:_____ Occupation:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance Plan Name:_____Your Relationship to Subscriber:_____

Insurance ID Number:_____Insurance Group Number:_____DOB of Subscriber_____

Secondary Medical Insurance Plan Name:_____Your Relationship to Subscriber:_____

Insurance ID Number:_____ Insurance Group Number:_____ DOB of Subscriber_____

Tertiary Medical Insurance Plan Name:_____Your Relationship to Subscriber:_____

Insurance ID Number:_____ Insurance Group Number:_____ DOB of Subscriber_____

VISION INSURANCE INFORMATION

Vision Insurance Plan Name:_____Your Relationship to Subscriber:_____

Insurance ID Number:_____ Insurance Group Number:_____ DOB of Subscriber_____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION

BLISS EYE ASSOCIATES

REVIEW OF SYSTEMS			
	YES	**NO**	**If YES, please list treatment(s) and dates**
Chronic fever, unexpected weight loss/gain, fatigue	□	□	
Ear/nose/throat problems (allergies, hearing loss or thyroid)	□	□	
Heart problem (high blood pressure, heart attack, surgery)	□	□	
Respiratory problems (asthma, short of breath)	□	□	
Gastrointestinal (ulcer, colon disease)	□	□	
Urinary (kidney failure, prostate disease)	□	□	
Skin problem (Rosacea, chronic acne)			
Musculoskeletal problem (Arthritis, Osteoporosis)	□	□	
Neurological (stroke, seizures)	□	□	
Mental Health problem (depression, forgetfulness)	□	□	
Diabetes (please list type and the date of onset)	□	□	
Cancer (please list type of cancer and the treatment)	□	□	
Other Health Conditions	□	□	

Responsible Person Name:_____DOB:_____

Address: (if different than above):_____

Relationship to Patient:_____ Social Security Number:_____

Employed By:_____ Work Phone:_____

Appointment Date: _____ **Patient Name: _____**

Patient DOB: _____

FAMILY HISTORY			
		Which family member?	**Explanation**

No pertinent family history of medical conditions/diseases	□		
Family history unknown	□		
----------EYE PROBLEMS----------	**YES**		
Blindness	□		
Glaucoma	□		
Corneal Disease	□		
Keratoconus	□		
Corneal Transplant	□		
Macular Degeneration	□		
Diabetic Retinopathy	□		
Retinal Detachment	□		
Retinitis Pigmentosa	□		
Other Eye Problems	□		
----------MEDICAL PROBLEMS----------	**X**	**Which family member?**	**Explanation**
Cancer	□		
Diabetes	□		
Thyroid	□		
Hypertension	□		
Stroke	□		
Heart Disease	□		
Other Health Conditions	□		

SOCIAL HISTORY	YES	NO	If YES, please provide detail
Do you smoke?	□	□	
Do you drink alcohol?	□	□	
Do you use recreational drugs?	□	□	

Appointment Date: _____ **Patient Name:** _____

Patient DOB: _____

OCCUPATION SPECIFIC ACTIVITIES	Write your answer in this field below
Occupation	
Vision-related activities	

EYE SURGERY HISTORY (if none, please write none)

	Surgery Performed	Date of Surgery	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			

PAST OTHER SURGERIES (if none, please write none)

	Surgery Performed	Date of Surgery	Surgeon

1.			
2.			
3.			
4.			
5.			

ALLERGY LIST (if none, please write none)			
	Allergies	**Reaction**	**Notes**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

CURRENT MEDICATIONS LIST (if none, please write none)			
	Name of Drug	**Dosage**	**Prescribed by**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

FAMILY DISCUSSION FORM

Date: _____

I, _____ give my permission for

Bliss Eye Associates to discuss my medical information with my family members.

Specific family members only:

BLISS EYE ASSOCIATES

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

☐ Check this box for permission to speak with **ANY** family member.

☐ Check this box if you **DO NOT** give permission to speak with family members.

Patient Signature: _____