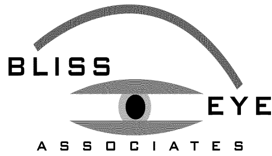


ABOUT OUR PRACTICE

LEWIS S. BLISS, M.D. graduated Cum Laude from the University of Texas, Medical Branch in 1982. His internship was served at Alton Ochsner Medical Foundation Hospitals in New Orleans, Louisiana. He then returned to UTMB for his residency in ophthalmology. He has been in private practice in Carmichael since 1986 treating thousands of patients for eye disease and performing thousands of ophthalmic surgeries. Dr. Bliss is a Diplomate of the American Board of Ophthalmology and a Fellow of the American Academy of Ophthalmology. He was appointed to the original advisory council of Sacramento Laser Vision and has served as Chairman of Ophthalmic Surgery for Mercy San Juan Hospital and Mercy San Juan Outpatient Surgery Center. Dr. Bliss continuously studies and implements advances in eye surgical techniques from around the world.

KEITH YAMANISHI, O.D. joined Bliss Eye Associates in March 1997. Dr. Yamanishi has an American Board Certification in Medical Optometry and is therapeutics and glaucoma certified. He graduated from the University of California, Berkeley School of Optometry in 1989. His clinical training continued in his residency program at the West Los Angeles V.A. Hospital. Dr. Yamanishi provides comprehensive eye exams to evaluate the health of the eye, he participates in pre-operative and post-operative assessments, and he is an expert in contact lens fittings.

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.

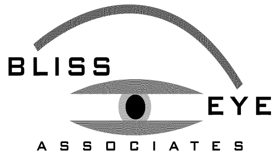
JEROME BRENDEL, O.D. graduated from The Southern California College of Optometry in May, 1984. His undergraduate degree is from The Colorado College in 1980, achieving a Bachelor of Arts degree in European, African, and Third World history. Dr. Brendel received his ocular therapeutics licensure in 1997. His optometric expertise lies in the areas of ocular pathology and disease detection, ocular therapeutic drug management, contact lenses, pediatric and geriatric optometry, cataract surgery co-management, laser refractive surgery co-management, as well as general family optometry. When not practicing optometry, Dr. Brendel enjoys golf, cycling, and watching his children perform and compete in cross country, track & field, cheer, and dance.

MONICA RODRIGUEZ-BAYES, O.D. graduated from the University of California, Berkeley School of Optometry. She completed her Bachelors of Arts in Biology at Amherst College in Massachusetts and her Masters of Science in Biology from Stanford University. She is board certified in the treatment of glaucoma and ocular diseases and completed externships at VA Reno, VA Puget Sound and Travis AFB focusing on primary eye care, contact lenses, low vision and ocular disease. In her free time, Dr. Rodriguez-Bayes enjoys running, hiking, and camping with her family.

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

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



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

OFFICE HOURS: We are open Monday - Friday from 7:30 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. Bliss 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.

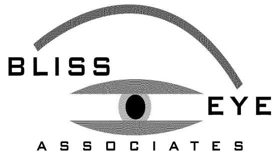
The bifocal/multifocal implant lens takes the prescription power you currently have in your bifocals or reading glasses and allows us to place it directly into the eye at the time of cataract surgery. This means many of our patients actually have better unaided vision following cataract surgery than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



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. The minimum fee for a contact lens evaluation in a patient currently wearing contact lenses is $40.00. 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 $35.00 and 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.

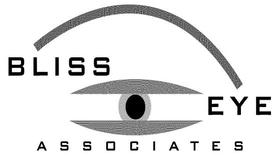
Lenses with scratch resistant coatings, anti-reflective coatings, polycarbonate, Trivex®, hi-index, progressive or Transitions are covered for a 1-year scratch resistant warranty, as long as the lens has normal wear and tear with no apparent abuse.
Progressive lenses are covered under a 60-day non-adaptation 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 Lewis S. Bliss, M.D., or any of his employed associate doctors be made to Lewis S. Bliss, M.D. 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

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

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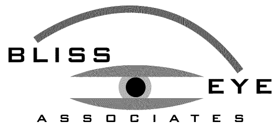
Sacramento CA 95841
(916) 863-3143 blisseye@blisseye.com www.blisseye.com



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.

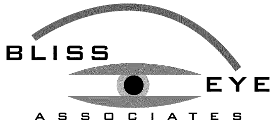
Responsibility: This office maintains confidentiality of patient information.

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: _____________________________



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) BLISS YAMANISHI KENNEDY YOSHIMURA LOPEZ BRENDEL

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:________________________

<u>MEDICAL INSURANCE INFORMATION</u>

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_______

<u>VISION INSURANCE INFORMATION</u>

Vision Insurance Plan Name:______________________Your Relationship to Subscriber:___________________

Insurance ID Number:_______________ Insurance Group Number:__________ DOB of Subscriber_________

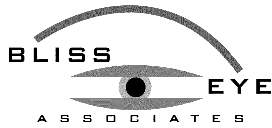
<u>IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION</u>

Responsible Person Name:________________________________DOB:____________________________

Address: (if different than above):____

Relationship to Patient:_____________________ Social Security Number:____________________________

Employed By:____________________________ Work Phone:___________________________________



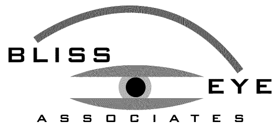
Appointment Date: ______________________ **Patient Name:** _____________________________________

Patient DOB: ______________________________________

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	☐	☐	

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: ____

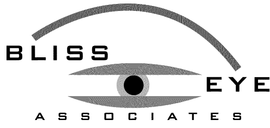
OCCUPATION SPECIFIC ACTIVITIES	Write your answer in this field below
Occupation	
Vision-related activities	

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:

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: ____ Patient DOB: __________________