

VERDUGO EYE CARE ASSOCIATES

Jeannine Scheinhorn, M.D.
1808 Verdugo Boulevard, Suite 103
Glendale, California 91208
Telephone (818) 790-0702 Fax (818) 790-2708

Welcome to our practice!

Dear _____:

We would like to welcome you to our office and thank you in advance for giving us the opportunity to participate in your eye care needs.

Your appointment is scheduled as follows:

Day: _____ **Date:** _____ **Time:** _____

Please arrive a few minutes prior to your appointment time for registration purposes; **AND** bring with you the enclosed patient information sheet (completed), your insurance card(s), referral, co-pay if applicable, a list of all medications you are currently taking and your current eyeglasses or contact lenses.

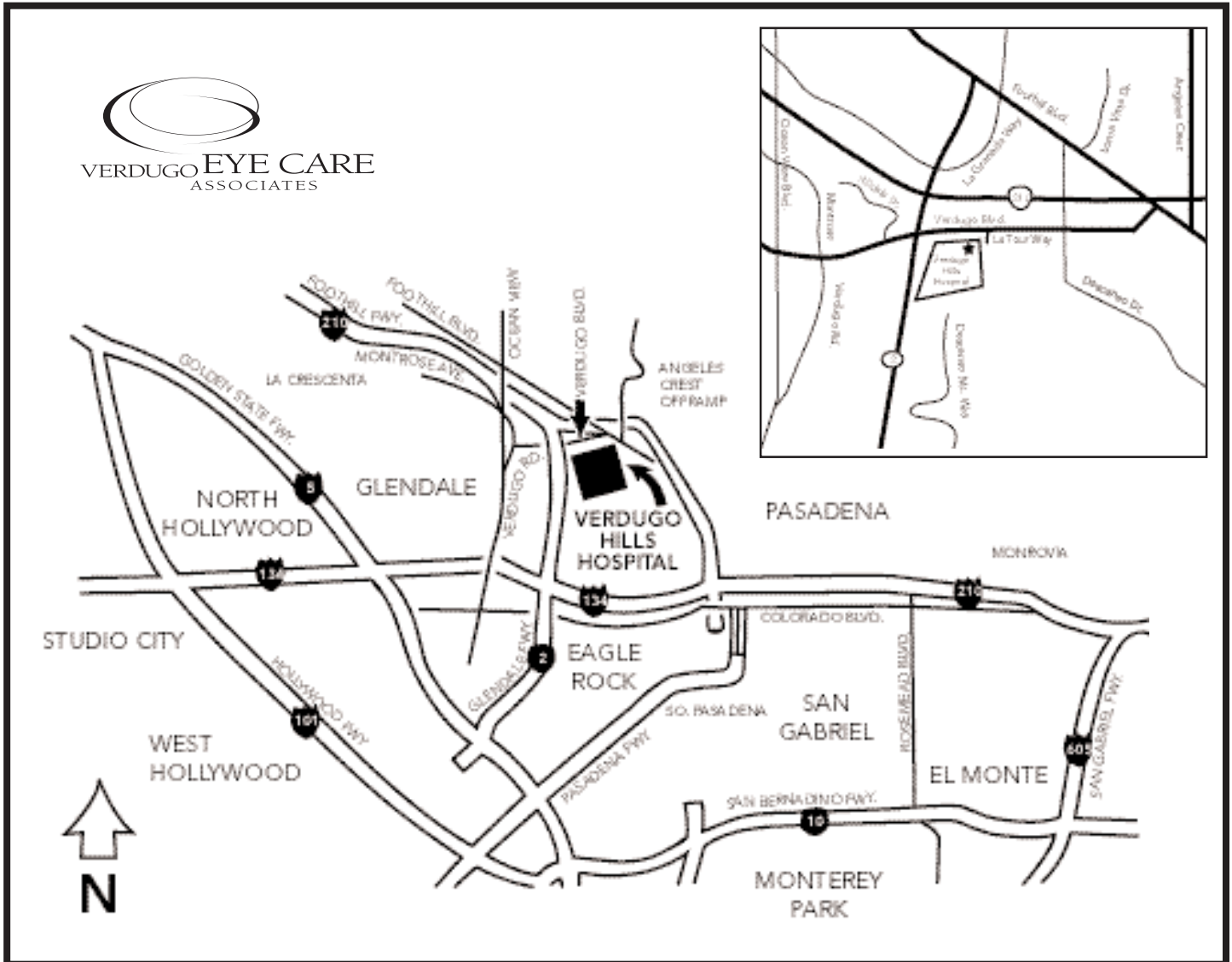
Please be advised most insurance plans, including Medicare and secondary insurance plans, do not cover refractions. A refraction is the part of the exam that determines your prescription or need for glasses. This is not considered part of a "complete eye exam" unless you have a special vision plan (such as VSP). The fee for a refraction is \$40.00 and is due at the time of your appointment. In addition, the prescriptions we dispense are for spectacles and, if applicable, may be converted to a contact lens prescription by a licensed contact lens professional.

We will be happy to bill most insurance plans as a courtesy to you. If your insurance plan requires a form, please bring it with you to your appointment (this does not apply to VSP; we will obtain benefits for you). Please be advised we will make 2 attempts to collect from your insurance company. Our office is conveniently located off the 2 Freeway North (Verdugo BOULEVARD exit, **NOT** Verdugo ROAD) at 1808 Verdugo Boulevard, Suite 103, Glendale, CA 91208. We also offer free, convenient parking in front of the Verdugo medical building. For your convenience, we have enclosed a map.

We look forward to meeting you at your scheduled appointment time. If we may be of any further assistance, please feel free to call our office at (818) 790-0702.

Dr. Scheinhorn and Staff

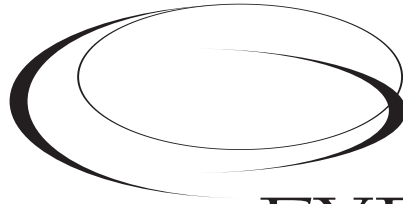
Map and Directions to Dr. Scheinhorn's Office



From the East (Pasadena, Monrovia, Rosemead), take the 210 West and exit on Angeles Crest. Turn left on Angeles Crest (away from the mountains). Turn right on Foothill. Turn left on Verdugo Blvd. Turn left on La Tour Way into our parking lot.

From the West (La Crescenta, Sunland, Tujunga), take the 210 East and exit on Ocean View Blvd. Turn right on Ocean View (away from the mountains). Turn left on Montrose. Turn left on Verdugo Blvd. Turn right on La Tour Way into our parking lot.

From the South (Glendale, Eagle Rock, or Los Angeles), take the 2 freeway North. As you approach the 210 Freeway interchange, get in the far right lane. Exit toward the 210 East/Pasadena ramp and exit on Verdugo Blvd. (not Verdugo Road). Turn right onto Verdugo Blvd. Turn right on La Tour Way into our parking lot.



VERDUGO EYE CARE ASSOCIATES

1808 Verdugo Boulevard, Suite 103
Glendale, California 91208
Telephone (818) 790-0702 Fax (818) 790-2708

PATIENT INFORMATION – PLEASE PRINT

TODAY'S DATE: _____

FAMILY PHYSICIAN: _____

REFERRED BY: _____

PHYSICIAN ADDRESS: _____

PHONE NO.: _____

1. LAST NAME Mr. Mrs. Miss	FIRST NAME	INITIAL	14. NAME OF EMPLOYER
2. STREET ADDRESS			15. ADDRESS
3. CITY	STATE	ZIP	16. OCCUPATION
4. DATE OF BIRTH MO DAY YEAR	AGE		17. NAME OF SPOUSE
5. SEX n MALE n FEMALE	MARITAL STATUS M S W D		18. SPOUSE'S EMPLOYER
6. SOCIAL SECURITY NO.			19. SPOUSE'S EMPLOYER'S ADDRESS
7. HOME PHONE ()	WORK PHONE ()		20. PHONE NUMBER ()
8. MEDICARE n YES n NO	MEDICARE NUMBER		21. NAME OF RESPONSIBLE PARTY PHONE NUMBER ()
9. MEDI-CAL n YES n NO	MED-ICAL NUMBER		RESPONSIBLE PARTY'S ADDRESS
10. OTHER INSURANCE COMPANY			CITY STATE ZIP
11. GROUP NUMBER	MEMBERSHIP NUMBER		22. NEAREST RELATIVE (NOT LIVING WITH YOU) PHONE NUMBER ()
12. OTHER INSURANCE COMPANY			23. NAME OF NEAREST FRIEND
13. GROUP NUMBER	MEMBERSHIP NUMBER		24. DRIVER'S LICENSE NUMBER

THE DILATING DROPS USED IN YOUR EYES AS PART OF THE EXAMINATION MAY BLUR YOUR VISION AND MAKE IT UNSAFE TO DRIVE. PLEASE DO NOT ATTEMPT TO DRIVE UNTIL YOU ARE CERTAIN THE EFFECT OF THE MEDICINE HAS WORN OFF. THE EFFECT OF THE DROPS USUALLY LASTS ABOUT ONE HOUR.

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED.

MEDICARE LIFETIME ASSIGNMENT AUTHORIZATION

Name of Beneficiary _____

HIC Number _____

I request that payment of authorized Medicare benefits be made to (physician's name) on my behalf for any services furnished me by that physician. I authorize any hold of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Beneficiary Signature _____ Date _____

MEDIGAP AUTHORIZATION

Beneficiary Name _____

HIC Number _____

I request the payment of authorized Medigap benefits be made to (physician's name) on my behalf for any services furnished to me by that physician. I authorize any hold of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services until this authorization is revoked.

Beneficiary Signature _____ Date _____

Nearest Relative In Case of Emergency _____ Relationship to Patient _____

Address _____ City _____ State _____ Phone (____) _____

AUTHORIZATION AND ASSIGNMENT

I authorize Jeannine Scheinhorn, M.D., a medical corporation, to provide care and treatment and to release medical information that may be requested by insurance companies to whom I have submitted a claim, and hereby request _____ Insurance company, to pay Jeannine Scheinhorn, M.D., a medical corporation, 1808 Verdugo Blvd., Suite 103, Glendale, CA, all benefits accruing to me under my Surgical, Hospitalization and Medical Plan. I understand I am financially responsible to the physician for all charges not covered by this assignment.

Signature _____ Witness _____

ELIGIBILITY GUARANTEE (PRE-PAID PLANS ONLY)

I, _____, hereby certify that I am eligible for the Health Maintenance Organization mentioned above and that I have chosen _____ as my participating medical group. I understand that if I am not eligible or have not received prior authorization, I am responsible for all charges for services rendered.

CASH BASIS ONLY

I understand I am financially responsible to Jeannine Scheinhorn, M.D., a medical corporation, for all charges for services rendered.

Signature _____