PACIFIC EYE & EAR
Specialists


**Chester F. Griffiths MD, FACS**
Cosmetic & Reconstructive Surgery
Nasal and Sinus Surgery
Head and Neck Surgery
Ear, Nose & Throat
Adults and Children

**Kian Karimi MD**
Cosmetic & Reconstructive Surgery
Nasal and Sinus Surgery
Head and Neck Surgery
Ear, Nose & Throat
Adults and Children

**Terah Allis MD**
Ear, Nose & Throat
Adults and Children

**Cadvan O. Griffiths MD, LLB**
Cosmetic & Reconstructive Surgery
Medical Legal Consultant

**William W. Lee MD, FACS**
Ear, Nose & Throat
Adults and Children

**Howard R. Krauss MD**
Ophthalmology
Neuro-Ophthalmology
Orbital & Strabismus Surgery
Cataract & Laser Vision Correction
Oculoplastic Surgery

**Jeremy E. Levenson MD**
Ophthalmology
Cornea/External Disease of Eye

**Gregory Frazer AuD, PhD, CCC-A**
**Carissa Bennett AuD, CCC-A**
**Julie Skille AuD, CCC-A**
**Kathy Harlan MA, CCC-A**
**Sofiya Analaryan AuD, CCC-A**
Audiology
Balance Testing/Therapy
Hearing Aids
Adults and Children

11645 Wilshire Blvd 6th Floor
Los Angeles, California
Ph (310) 477-5558
Fax (310) 477-7281

PacificSpecialists.com

An Association, Not a Group Practice

West Wilshire Medical
Surgical Center, LTD, INC


# Welcome To Our Practice

We are very happy to welcome you to our multi-subspecialty office and surgical center. We appreciate your trust in us to take care of you and your family. Our office is focused on providing you with the highest quality of care. Our friendly staff is here to assist you.

Please complete the enclosed forms and bring them with you on your first appointment:

**Patient Registration Form** **Health History Form** **Financial and Payment Policy**

**Directions to Our Office are included**

**Please Note:** We are Contracted Providers for **MULTIPLAN** and accept assignment for **Traditional Medicare Programs, (except Dr. Krauss),** and will bill the insurance for you, (We do not accept HMO, Medicare HMO, Medi-Cal or Medicare Advantage Plans).

**Dr Krauss patients: If we are not preferred providers for your insurance carrier you will be responsible for payment at the time of your visit.** The amount will depend on the nature and extent of your own evaluation and management, but will be between $150-$800. We will provide a copy of your bill for you to submit to your insurance company for any reimbursement. Dr. Levenson patients that have Medicare will only be responsible for a refraction fee of $50, if we provide this service to you, as well as deductibles or co-pays, if not covered by your secondary insurance.

We would like you to be aware of the other services we are able to offer to our patients:

**Laser Services**
- Hair Removal
- IPL PhotoFacial
- Pro-fractional Laser
- Vein Removal
- Micro Laser Peel
- Skin Resurfacing
- Acne/ Rosacea Therapy

**Hearing & Balance**
- Hearing Tests
- Vestibular/ Balance Testing
- Hearing Devices
- Tinnitus Evaluation

**Ear, Nose & Throat**
- Pillar (Snoring Procedure)
- Sinus Surgery
- Tonsillectomy
- Thyroid Surgery
- Nasal Breathing
- Facial Skin Cancers
- Voice Care

**Ophthalmology**
- Eye & Vision Care
- Contact Lens Fittings
- Corneal/External Diseases
- Refractive, Cataract & Lens Implant Surgery
- Dry Eye Surgery
- Glaucoma Laser Surgery
- Oculoplastic Surgery
- Diagnostic Testing;

  Goldmann Perimetry,
  Humphrey/Octopus Visual Fields
  Ocular Photography
  Ocular Coherence Tomograpghy
  Corneal Topography
  Ocular Biometry
  Ultrasonography
- Strabismus Surgery
- Medical & Surgical Management of Thyroid Eye Disease
- Neuro-Ophthalomology
- Orbital Surgery

**Cosmetic Procedures**
- Blepharoplasty (Eyelid)
- Rhinoplasty
- Otoplasty (Big ear revision)
- Brow Lift
- Chin, Cheek Implants
- Breast Augmentation
- Liposuction
- Fat Transfer Filler
- Botox®
- Dysport™
- FILLERS:
  Restylane®
  Radiesse®
  Juvaderm®
  Sculptra®
  Belotero®
  Latisse®

Please visit our websites for more information:
**PacificSpecialists.com • PacificCosmeticSurgeons.com • SnoreImprovement.com**
Thank you for choosing our office, we look forward to meeting you

PACIFIC EYE & EAR
Specialists

T (310) 477-5558 F (310) 477-7281

Date: _____ **Email:**_____ ACCT.#:_____

Please print legibly

To improve communication, I authorize use of email: _____**initials**

*PATIENTS PERSONAL INFORMATION* ***Due To New Federal Regulations We Must Ask The Following Questions***

*Race* ☐ American Indian/Alaska Native ☐ Asian *Ethnicity* ☐ Hispanic ☐ Non-Hispanic *Language* _____

☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Other Age _____ Sex ☐ F ☐ M

Name:_____

*Last Name (apellido)* *First Name (primer nombre)* *Middle Initial*

How do you wish to be addressed?_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street address:_____(Apt #_____) City:_____ State:_____ Zip:_____-_____

*(domicilio)* *(cuidad)* *(estado)* *(zona postal)*

Primary: (____) _____ Secondary: (_____) _____ Other: (_____)_____

☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

Date of Birth:____/____/____ Driver's license (State):_____ Social Security#:_____

*(fecha de nacimiento)* *(licencia de conducer)* *(número de seguro social)*

Spouse or parent's name (if minor):_____

*PATIENT/RESPONSIBLE PARTY INFORMATION*

Responsible party:_____ Self ☐ Spouse ☐ Other ☐

Responsible party's home phone: (_____) _____ Work phone: (_____) _____

Address:_____ (Apt #_____) City:_____ State:_____ Zip:_____

*(domicilio)* *(cuidad)* *(estado)* *(zona postal)*

Employer's name:_____ Phone number: (_____) _____

*(nombre de trabajo/compañía)* *(teléfono de trabajo)*

Your occupation:_____

*(nombre de empleo)*

*PATIENT'S INSURANCE INFORMATION*

PRIMARY insurance company's name:_____

Name of insured:_____ Date of birth:_____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number: _____ Group number:_____

SECONDARY insurance company's name:_____

Name of insured _____ Date of birth:_____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number:_____ Group number:_____

*PATIENTS REFERRAL INFORMATION*

Referred by:_____Phone:_____

*(referencia, médico quien lo/la recomendó?)* *(teléfono de doctor)*

*EMERGENCY CONTACT*

Name of person:_____

*(NAME ONLY, contacto de emergencia)*

Phone Number (primary): (_____) _____

Phone number (secondary): (_____) _____ Relationship:_____

I hereby acknowledge that a copy of Pacific Specialists Notice of Privacy Practices was made available to me

_____

Signature

_____

Date

_____ _____ _____

*Signature (firma)* *Print Name (en letra de molde)* *Date (fecha)*

PACIFIC EYE & EAR
Specialists

# ADULT SHEET

*Please write additional information on the back*

PATIENT NAME _____ AGE _____ DATE _____

**Height** _____'_____" **Weight** _____**lbs. Pain 0 1 2 3 4 5 6 7 8 9 10 Where?** _____

What is the reason for your visit today? _____

**Please List Your Pharmacy Name And Phone:** _____

**LIST CURRENT MEDICATIONS,**

**Including Vitamins & Supplements** (if you are taking aspirin/Advil or diet pills list the duration)

| | | |
|---|---|---|
| | | |
| | | |
| | | |

| | | | |
|---|---|---|---|
| MEDICATION ALLERGIES | | | |
| OTHER ALLERGIES | | | |

**PAST MEDICAL HISTORY (type and date) :**

| | | | |
|---|---|---|---|
| *Hospitalizations* | | | |
| *Operations* | | | |
| *Illnesses* | | | |
| *Injuries/Fractures* | | | |

REVIEW OF SYSTEMS (check any that apply):

| | | | | |
|---|---|---|---|---|
| *EARS:* | ☐ Hearing Aids<br>☐ Exposure to Loud Noise | ☐ Pain<br>☐ Tinnitus (noise in ears) | ☐ Dizziness/Vertigo<br>☐ Discharge | ☐ Surgery:_____<br>☐ Other:_____ |
| *NOSE* : | ☐ Difficulty Breathing<br>☐ Snoring | ☐ Stuffiness<br>☐ Nasal Sprays | ☐ Bleeding<br>☐ Injuries | ☐ Change in Smell ☐ Post Nasal Drip<br>☐ Surgery:_____ |
| *THROAT:* | ☐ Soreness<br>☐ Bad Taste<br>☐ Throat Clearing | ☐ Pain or Difficulty Swallowing<br>☐ Recent Dental Work<br>☐ Voice Change/Hoarseness | ☐ Tonsillitis<br>☐ Bad Breath<br>☐ Lump | ☐ Cough<br>☐ Reflux<br>☐ Surgery:_____ |
| *NECK:* | ☐ Lumps<br>☐ Pain | ☐ Thyroid Nodules<br>☐ Swollen Glands | ☐ Injuries<br>☐ Surgery:_____ | |
| *EYES:* | ☐ Loss/Blurred Vision<br>☐ Crossed Eyes<br>☐ Lazy Eye<br>☐ Eye Disease | ☐ Double Vision<br>☐ Itching, Burning, Irritation<br>☐ Floating Objects in Vision<br>☐ Cataracts | ☐ Injuries<br>☐ Pain/Soreness<br>☐ Dryness of Eyes<br>☐ Light Sensitivity | ☐ Excess Tearing<br>☐ Redness/Inflammation<br>☐ Glaucoma<br>☐ Surgery:_____ |

**PERSONAL HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Anemia | ☐ Chronic Lung Disease | ☐ Emphysema | ☐ Hepatitis or Jaundice | ☐ Paralysis | ☐ Shortness Of Breath |
| ☐ Angina/Chest Pain | ☐ Constipation | ☐ Headaches | ☐ Kidney Disease | ☐ Prostate Problems | ☐ Stroke |
| ☐ Anxiety | ☐ Colitis | ☐ Heart Failure/Attack | ☐ Kidney Stones | ☐ Psoriasis | ☐ Tuberculosis |
| ☐ Asthma | ☐ Diabetes | ☐ Heartburn | ☐ Liver Disease | ☐ Psychiatric | ☐ Ulcers |
| ☐ Arrhythmia | ☐ Diarrhea | ☐ High Blood Pressure | ☐ Lyme Disease | ☐ Rashes | ☐ Vaginitis |
| ☐ Bleeding Problems | ☐ Difficulty Urinating | ☐ Autoimmune Disease | | ☐ Rheumatic Fever | ☐ Weight Loss or Gain |
| | ☐ Eczema | ☐ Pain w/ Urination | | ☐ Sexual Dysfunction | |
| | | ☐ Cancer | | | |

**SOCIAL HISTORY :**

- Smoke : ☐ YES ☐ NO _____ packs per day
- Drugs: ☐ YES ☐ NO _____type/amount
- Caffeine: ☐ YES ☐ NO _____ cups per day
- Alcohol: ☐ YES ☐ NO _____type/amount
- Diet : _____ type
- Are you currently pregnant? ☐ YES ☐ NO

Are you currently on a Contraceptive medication program? ☐ YES ☐ NO

**FAMILY HISTORY (check any that apply) :**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Asthma | ☐ Diabetes | ☐ High Blood Pressure | ☐ Thyroid Disease | ☐ Hearing Loss | ☐ Bleeding Problems |
| ☐ Allergies | ☐ Cancer | ☐ Tuberculosis | ☐ Dizziness (vertigo) | ☐ Heart Disease | |
| ☐ Headaches | ☐ Stroke | ☐ Autoimmune Disease | ☐ Eye Problems | | |

**Has anyone in your family had an unfavorable reaction to anesthesia? ☐ YES ☐ NO Explain**_____

Is there anything else about your medical history that might be helpful for the doctor to know? _____

*I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.*

PATIENT SIGNATURE :_____ DATE: _____


PATIENT NAME: _____

SUPPLEMENTAL REGISTRATION INFORMATION

**Full name and address of referring physician:**

_ _____

_ _____

Telephone number: _____

Email Address of Physician:_____

**Full name and address of general physician/internist:**

_ _____

_ _____

Telephone number: _____

Email Address of Physician:_____

**Full names and addressed of other physicians you wish to receive reports:**

_ _____

_ _____

_ _____

Telephone number: _____

Email Address of Physician:_____

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Sofiya Krauss AuD
Carissa Bennett AuD

**West Wilshire Medical Surgical Center, Pacific Specialists Imaging, Pacific Cosmetic Surgeons, Pacific Hearing & Balance**

# Financial and Payment Policy for Medical or Surgical Services

**Insurance**

If you have medical insurance, we are pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually.

_____**initial**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand however, that: **WE ARE OUT OF NETWORK WITH ALL INSURANCE CARRIERS. WE HAVE A CONTRACT WITH MULTIPLAN, A CLAIM PRICING NETWORK. IF YOUR INSURANCE UTILIZES MULTIPLAN, WE WILL BILL YOUR INSURANCE AND YOU ARE RESPONSIBLE FOR THE CO-INSURANCE, CO-PAYMENT OR DEDUCTIBLE IN ACCORDANCE WITH THE OUT OFNETWORK TERMS OF YOUR PLAN.** We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure that our fees are consistent with the charges in the geographic region. Some reputable insurance companies consider our fees usual, customary, and reasonable. Not all services are a covered benefit in all contracts. It is the patient's responsibility and duty to have an understanding of the benefits and eligibility, stipulated under their individual insurance policy. **We may contact your insurance carrier to verify coverage information prior to rendering Surgical Services ONLY.**

_____**initial**

**Payment for Services**

1. **Multiplan**: We will bill your insurance; you are responsible for Co-payments, Co-Insurance or Deductibles. Audiology services are contracted and will be billed under your In Network Benefits.
2. **Traditional Part B MEDICARE Patients**: ALL providers, except Dr. Krauss, accept assignment and will bill Medicare.
3. **We do not participate in any HMO, Medicare Advantage Plans or Medi-Cal**
4. **Hearing Services**: Pacific Hearing and Balance are contracted providers for MOST insurance carriers. Please verify.
5. **Out of Network Benefits**:
    a. **Dr. Krauss:** Payment for services is due at the time services are rendered. A copy of the superbill will be given to you to assist you in your billing insurance. We will not bill your insurance for you.
    b. **ENT Services**: Payment is due at the time of service if you are a Blue Shield or Blue Cross Individual Provider member or receiving cosmetic treatments. Otherwise, we will bill the insurance and you are responsible for the unpaid portion.
    c. **West Wilshire Medical Surgical Center, Inc**: Payments for out of network benefits will be collected in accordance with the signed and agreed upon financial agreement.

It may become necessary for you to pay your account in full if your insurance company fails to pay for services. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements**. We must emphasize that as medical care providers, our relationship is with YOU, not your insurance company**. Your insurance is a contract between you, your employer and the insurance company.

_____**initial**

**Assignment of Benefits**

I request that payment of the authorized Medicare and/or other insurance benefits be paid on my behalf to my Provider. I hereby assign to my Provider all my rights, title, interest in and to any and all health care/or surgical benefits, otherwise payable to me for medical treatment including emergency medical services. In absence of such payment, Provider is further assigned all necessary right to enforce collection of such payments or benefits, including the rights to file a lawsuit or demand arbitration directly against the insurer, plan or payer. I further agree that I am financially responsible for charges not collected by this Agreement. I authorize the provider to contact the employer and/or company responsible for the payment of any benefits for the purpose of determining the existence and extent of benefits, and I authorize the release of any and all information in possession of the employer and/or company necessary to determine the existence and/or extent of such benefits. For and in consideration of services rendered, I agree that this Provider shall have an irrevocable lien, equal to the charges for the services rendered on any recovery due the patient because of injury or illness which required this Providers' services, whether said recovery is by judgment, settlement, arbitration award, hearing award, compensation or insurance payment.

_____**initial**

Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Thank you.

**My Signature below constitutes acknowledgement and acceptance of this policy.**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient or Guarantor Signature | Print | Date | Witness |

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T (310) 477-5558 F (310) 477-7281

## Directions and Parking

For door to door directions visit us at: PacificSpecialists.com

**Brentwood**
11645 Wilshire Blvd. 6th Floor
Los Angeles, CA 90025


**PARKING**: The building has a subterranean garage for visitor parking. They charge $3 every 15 minutes, with a maximum of $24, Monday through Friday. After 6 pm and on weekends they charge a flat $2 fee. The automated system requires ticket payment in the parking foyer.

Limited metered street parking is available on Barry and the surrounding streets. Please be sure to read all posted signs and fill the meter

We have the entire 6th floor at 11645 Wilshire Blvd., between Federal and Barrington, on the corner of Barry.