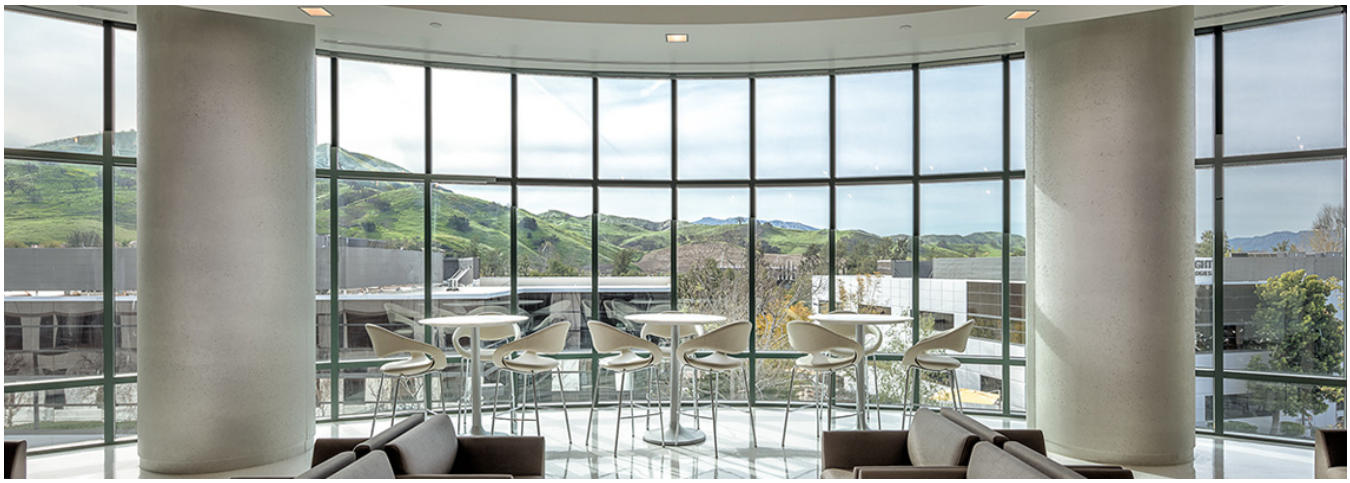
UCLA Stein Eye Institute

Welcome to Dr. Shawn Lin's Clinic. We are excited to meet you!



Your Appointment

Name: _____ UCLA ID: _____

Day: _____ Date: _____ Time: _____

Our Address / Phone

26575 Agoura Rd, 3rd floor
Calabasas, CA 91302

(310) 206-7955

Parking

FREE covered parking is available in the building. Take the elevator to the 3rd floor from the parking lot.

What to bring

- Eye Medical Records – if you are referred from another eye doctor
- Current Prescription Glasses / Sunglasses / Leave contact lenses off if possible
- Insurance Card(s) / Authorization if required (call insurance company) / Copayment
- **If you are unable to make your appointment, please let us know as soon as possible and we will be happy to arrange a different time.**

UCLA Stein Eye Institute

What to expect

Please allow 2-3 hours for your examination. We will dilate your eyes to perform a full eye exam. Dilation lasts for 2-3 hours, during which your near vision will be blurry, but your distance vision should be unaffected. You may experience increased light sensitivity, but most patients are able to drive themselves home following the appointment. Some patients prefer to bring a family member or friend to help drive them home. Bring sunglasses if possible.

If any additional testing or lab work is needed, this may require additional time.

Directions

Our Office Telephone: (310) 206-7955

UCLA Stein Eye Institute

HARVARD UNIVERSITY Stanford MEDICINE UCLA Health

Dr. Lin understands that eye illness and eye surgery are significant life experiences which are unique for every patient. He is committed to treating every patient as he would his own family members, and bringing warmth and compassion to every visit.

Dr. Lin's practice is focused on precision cataract, refractive surgery, and corneal surgery:

- Femtosecond laser cataract surgery
- LASIK / PRK / SMILE refractive surgery
- Pterygium / pinguecula surgery
- Corneal transplants
- Keratoconus
- Dry Eye

Academic Titles

Medical Director | UCLA Stein Eye Center Calabasas
Associate Director | Ophthalmology Residency Program
Clinical Faculty | Division of Cataract & Refractive Surgery

Education

Harvard | Cornea, Cataract and Refractive Surgery Fellowship
UCLA | Ophthalmology Residency
Stanford | Medical School

Awards & Research

Dr. Lin is the recipient of the Heed Fellowship, awarded to the top 24 ophthalmologists each year in the United States, and the Abelson Fellowship, awarded to the top fellow at Harvard each year.

He has authored peer reviewed publications in leading ophthalmology journals: including the American Journal of Ophthalmology and the British Journal of Ophthalmology.

His research is focused on combining human and artificial intelligence to deliver exceptional surgical results to his patients.

Teaching

Dr. Lin is the founder of EyeGuru, an educational platform visited more than 300,000 times a year by ophthalmologists from over 125 countries around the world.

He was named the Associate Director of the Ophthalmology Residency program in 2019. In this role, Dr. Lin helps to lead training for the next generation of ophthalmologists.

He has written textbook chapters for the classic Practice of Ophthalmology textbook and the subspecialty Cornea textbook, and has delivered keynote presentations at national and international ophthalmology meetings.

General Billing Information

SELF PAY PATIENTS: If you are not covered by insurance, you will be expected to **pay in full at the time of service** by cash, check, or credit card. Fees for initial consultation vary depending on the complexity and nature of the examination and the time required, with a 30% discount applied on the date of service only.

INSURED PATIENTS: Please bring your insurance card(s), your copayment, and any unmet deductible payment with you to the doctor's office. We will keep a copy of the information in our chart and forward a copy on to our billing service. Be prepared to pay your deductible and copayment at the time of service. Please refer to your insurance handbook for copayment and deductible rules.

If you have an HMO or Medi-Cal with HMO benefits, please bring the authorization with you to the appointment or have your primary physician fax it to the office. Always double check if we received your authorization by calling our office. **If your insurance plan requires you to obtain an authorization, and a valid authorization is not received by the time of your appointment, we will have to cancel your appointment.**

Some services may not be covered by your insurance, in which case you will be responsible for the charges. Please refer to your handbook or contact your member services for assistance with covered benefits. For example, **a refraction is a non-covered service which is performed to determine a prescription for glasses. Refractions are rarely covered by insurance, so please come prepared to pay for it.**

MEDICARE PATIENTS: We do accept assignment on Medicare. This does not mean that what Medicare pays is accepted as payment in full. This does not mean that we accept Medicare's fee schedule for covered services. See your Medicare handbook for more information on non-covered services, such as refraction. The refraction is the procedure performed to determine if you need glasses or a change in glasses prescription, and does not necessarily need to be performed at every at every visit. It has never been covered by Medicare. Previously it was performed by the doctors at UCLA on a courtesy basis and was not billed to you or your Medicare, but recent health care law changes make it illegal for us to perform courtesy services for patients.

If you have Medicare but no supplemental insurance, you will be responsible for your Medicare deductibles, the refraction (if performed), and the 20% that Medicare does not pay. Please expect to pay at the time of service. It is against federal law and Medicare policy for the doctor to write off your deductible and any remaining balance.

GENERAL INFORMATION: Laboratory tests are not included in the doctor's fees. Tests often require separate authorizations from HMO's or other health plans.

UCLA Stein Eye Institute

Patient Label

PATIENT INFO

What brings you in today?

_____

How were you referred to Dr. Lin?

☐ UCLA Website ☐ Reviews Online ☐ Another Doctor, Dr. _____

Are you currently retired or working?

☐ Retired - Profession when working _____

☐ Employed - Employer _____ Occupation _____

What hobbies/ activities do you participate in? (this helps us better understand your visual needs)

_____

DEMOGRAPHICS

☐ I have seen other UCLA doctors, my information is in the system

Patient Name _____ Preferred "Nickname" _____
(Last) (First) (Middle)

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

DOB ____ / ____ / ____ Age _____ ☐ Male ☐ Female

Email _____

Insurance (Primary) _____ Insurance (Secondary) _____

Who are your current doctors?

Eye Doctor _____ Phone _____

General doctor _____ Phone _____

OCULAR HISTORY

Do you wear eyeglasses or contacts for distance vision? ☐ Full-Time ☐ Part-Time ☐ Not at all

Do you wear eyeglasses or contacts for reading? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind of contact lenses do you wear? ☐ Soft ☐ Toric ☐ Hard (RGP)

Have you tried monovision with contacts/glasses (one eye for distance vision, the other for reading)? ☐ Yes ☐ No

If so, was it successful for you? ☐ Yes ☐ No

Do you currently experience glare/halos around lights at night or have other night vision problems? ☐ Yes ☐ No

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OCULAR HISTORY (continued)

Have you ever had eye trauma? ☐ No

Do you have any other eye issues? ☐ No

Do you use any eye drops? ☐ No

Eye	Medication/ Instructions / Duration

Do you have any history of eye surgery? ☐ No

Year (approx)	Surgery/ Eye

MEDICAL HISTORY

Have you had any other surgeries (non-eye related)? ☐ No

Date	Surgery Description

Do you or anyone in your immediate family have any of the following conditions? (Check all that apply)

	You	Family
Atopic Disease		
Autoimmune disease		
Diabetes		
Hepatitis		
Acne		
Retinal disease		

	You	Family
Rheumatoid arthritis		
HIV infection		
Keloid formation		
Glaucoma		
Cataracts		
Mental illness / Depression		

Other medical problems (please list) _____

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If male, have you been diagnosed with BPH (benign prostatic hyperplasia) or prostrate disease? ☐ Yes ☐ No

Do you take (or have you ever taken) Flomax® or other medication for BPH or other prostate disease? ☐ Yes ☐ No

If female, are you or might you be pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

MEDICATIONS

What is your primary pharmacy? (name, street, and city)

_____

☐ None ☐ I have seen other UCLA doctors, my information is in the system

Medication (eg. Aspirin)	Dose (eg. 81mg)	Times per day (eg. 1)

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Patient Label

REVIEW OF SYSTEMS Do you have problems in any of the following areas? ☐ None

Body System	Yes	No	Description
Eyes (double vision, blurred vision, pain, redness, etc…)			
Ears/Nose/Throat (poor hearing, ringing, dizziness, etc…)			
Cardiovascular (high blood pressure, heart, blood vessels, etc…)			
Respiratory (asthma, shortness of breath, emphysema, etc…)			
Gastrointestinal (diarrhea, hepatitis, jaundice, ulcerative colitis, etc…)			
Genitourinary, Kidney, Bladder (kidney, urination, impotence)			
Female Reproductive (Are you pregnant of nursing?)			
Muscles, Bones, Joints (arthritis, muscle pain, stiffness, etc…)			
Skin (rashes, pimples, warts, skin cancers, etc…)			
Neurological (seizures, headache, migraine, stroke, paralysis, numbness, weakness, poor memory, imbalance)			
Psychiatric (autism, anxiety, depression, mania, PTSD, etc…)			
Endocrine (diabetes, thyroid problems, etc…)			
Blood and Lymph (bleeding tendency, leukemia, anemia, etc…)			
Allergy/Immunologic (eczema, lupus, food allergies, AIDS, etc…)			
Cancer (skin, breast, lung, blood, brain, kidney, bladder, etc…)			
Genetic Syndrome (neurofibromatosis, tuberous sclerosis, etc…)			

Is there anything else we should know?

_____

Authorization: I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as a valid as the original.

Signature _____ Date _____

Verified _____

UCLA Stein Eye Institute

Patient Label

Patient Responsibility Form

Most insurance plans including Medicare do not pay for routine office visits. Routine office visits include yearly check-up examinations, some examinations to screen for eye disease, and routine follow-up examinations more than 3 months after eye surgery. Most insurance plans will only pay for services that they determine to be "reasonable and necessary." If your insurance plan determines that a particular service is not "reasonable and necessary," they will deny payment for that service.

Most insurance plans will not pay for visits to ophthalmologists' offices, which result in nonmedical diagnoses such as normal eye exam, pseudo strabismus, myopia (nearsightedness), hyperopia (farsightedness), astigmatism, and presbyopia (farsightedness due to aging eyes). Eye exams with these diagnoses are considered "routine" even if it is determined that you need your vision corrected. Because our doctors cannot determine prior to examination whether a medical diagnosis will be found, we need to guarantee that the patient will be personally and fully responsible for the payment should a refractive or nonmedical diagnosis result from this visit.

Please acknowledge that you are fully responsible for payment if you belong to a managed care organization and do now obtain a proper referral authorization before your visit.

The exact amount depends on the nature and extent of the examination. Additional charges may apply for additional procedures and testing.

Yes, I have read and understand the statement above. I agree to be fully responsible for payment if this visit meets any of the criteria that qualify it as a routine office visit.

Signed _____ Date _____

Signature of Patient or Representative

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Refraction

(Non-Covered Service Waiver)

Most insurance plans including Medicare do not pay for refractions. Refraction is a measurement of the eyes to determine the prescription for glasses. It is considered a routine component of the complete eye examination.

It will be charged any time a refraction is performed whether or not it results in a prescription for glasses. It is an essential part of an eye examination, but it is **NOT** a covered service by Medicare or most insurance companies regardless of the reason for the test being performed. The refraction charge covers prescription verifications and prescription changes for 3 months following the initial measurements. Our ophthalmologists are contracted with certain medical insurances but are not contracted with any vision plans (e.g VSP, Eyemed, MES, etc.)

Our office fees for refraction is **$75** and is collected at the time of service in additional to the patient's copay. There is a separate charge for contact lens evaluations as well as refractions.

Yes, I have read and understand the statement above. I agree to be fully responsible for the non-covered amounts.

Signed _____ Date _____

Signature of Patient or Representative

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Patient Label

EMAIL CONSENT FORM

- UCLA Health Systems
- Santa Monica UCLA Medical Center and Orthopedic Hospital
- Stewart and Lynda Resnick Neuropsychiatric Hospital

You and your Health care provider have agreed to correspond using electronic mail (E–mail). This form provides guidelines for the intended use of this type of communication, and documents for your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E–MAIL. CALL 911

E–Mail Use:	Generally, e–mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
Privacy and Confidentiality:	Unless your provider tells you specifically that the e–mail will be conducted via a secure server, consider e–mail like a postcard that can be viewed by unintended persons. In addition, the content of the e–mail may be monitored by the hospital to ensure appropriate use. Discuss with your provider who will process your e–mail messages during business hours, vacations or illness. All e–mails regarding your care will be included in your medical record.
Creating a Message:	On the "Subject" line, include the general topic of the message, for example, Prescription or Appointment or Advice. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.
Content of The Message:	E–mail should be used only for non–sensitive and non–urgent issues. Types of information appropriate for e–mail include: • Questions about prescriptions • Routine follow–up inquiries • Appointment scheduling • Reporting of self–monitoring measurements, such as blood pressure and glucose determinations. According to the California law, your provider may not communicate any lab results unless your e–mail correspondence is conducted through a secure server. Additionally, e–mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

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EMAIL CONSENT FORM

Response Time:	Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number below.
Ending E–Mail Relationship:	Either you or your provider may request via e–mail or letter to discontinue using e–mail as a means of communication.
Disclaimer:	**UCLA Health System, Santa Monica UCLA Medical Center and Orthopedic Hospital and Stewart and Lynda Resnick Neuropsychiatric Hospital are not responsible for e–mail messages that are lost due to technical failure during composition, transmission and/or storage.**

I have read and understand the information above, and have had any and all questions answered to my satisfaction. I agree to the guidelines for e–mail communication.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient:

_____

Patient E–mail address (please print) _____

Provider Name _____ Telephone Number _____

Provider E–mail address (please print) _____

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When you are done with this form, please notify a member of our staff so we can care for you promptly.