DATE	PROFESSIONAL SERVICE	CHARGE	CREDITS: PAYMENTS	CREDITS: ADJ.	BALANCE	NAME
6/12/18	Toric CL Exam	159 -	159 -			Hill, Richard

You **PAID** this amount _____

This is a **STATEMENT** of your account to date _____

Date of Service 6/12/18

PATIENT: _____

GENERAL DIAGNOSTIC & TREATMENT SERVICES

	New	Estab.	Fee
☐ Minimal	99201	99211	
☐ Brief	99202	99212	
☐ Limited	99203	99213	
☐ Intermediate	99204	99214	
☑ Comprehensive	99205	99215	

INDEPENDENT DIAGNOSTIC PROCEDURES

☐ Gonioscopy	92020	
☐ Visual Field Examination	92081	
☐ Tonometry	92100	
☐ Provocative Test, Glaucoma	92140	
☐ Extended Color Vision Exam	92283	
☐ External Ocular Photography	92285	
☐ Pachymetry	V0504	
☐ Extended Ophthalmoscopy	92225	
☐ Ophthal. Fundus Photography	92250	
☐ _____		

PRISM THERAPY SERVICES

☐ Prolonged Occlusion Service	V0350	
☐ Diagnostic Prism Service	V0351	
☐ Prism Therapy Service	V0360	
☐ _____		

ANISEIKONIC DIAG. & TREATMENT SERVICE

☐ Aniseikonic Diagnostic Service	V0300	

CONTACT LENS TREATMENT SERVICES

☑ C.L. Diagnostic Service Only	V0500	59
☐ PMMA Spherical	V0510	
☐ PMMA Toric or Prism	V0511	
☐ PMMA Bifocal	V0512	
☐ PMMA Keratoconus	V0530	
☐ Gas Perm. Spherical	V0520	
☐ Gas Perm. Keratoconus	V0534	
☐ Hydro., Spherical	V0516	
☐ Hydro., Toric or Prism	V0517	
☐ Hydro., Bifocal	V0518	30
☐ Hydro., Extended Wear	V0524	
☐ Orthokeratology	V0540	
☐ Therapeutic Contact	92070	
☐ Aphakia, PMMA, Spherical	V0551	
☐ Aphakia, Gas Permeable	V0582	
☐ Aphakia, Hydro, Sphere	V0561	
☐ Aphakia, Hydro, Ext. Wear	V0591	
☐ Monocular Modifier	-52	
☐ C.L. Replacement Modifier	-62	
☐ C.L. Replacement	92326	
☐ _____		

OTHER SERVICES

☐ Prosthetic Eye Services	92330	
☐ Correction of Trichiasis	67820	
☐ _____		

TREATMENT MATERIALS

	FEE
☐ _____	
☐ _____	
☐ _____	

TOTAL FEE $159 -

Payment Arrangement:

Visa

PATIENT: Please keep this record for Income Tax or Medicare & Insurance purposes. See back of pink copy for insurance instructions.

LENS PRESCRIPTION

	SPHERE	CYLINDER	AXIS	PRISM
R:	-4.00	-1.00	180	
L:	-6.75	-1.00	180	
ADD:				

DIAGNOSIS:

☐ Abrasion, Cornea 1-R 2-L	S05.0_XA	☐ Convergence Insuff.	H51.11	☐ Nystagmus	H55.00
☐ Accommodation Spasm 1-4 2-L 3-B	H52.53_	☐ Divergence Excess	H51.8	☐ Ocular Motor Dysf. 0-Strabismus	
☐ Accommodation Int. Ophthal.	H52.51_	☐ Dry Eyes 1-RLG 2-LLG 3-BLG	H04.12_	1-Binocular Movement	H5_.9
☐ Abnormal Retinal Correspondence	H53.31_	☐ Edema, Corneal	H18.20	☐ Paresis 1-R 2-L 3-B	H49.4
☐ Amblyopia	H53.00_	☐ Esophoria	H50.51	☐ Photophobia 1-R 2-L 3-B	H53.14_
☐ Aniseikonia 1-R 2-L 3-B	H52.32_	☐ Esotropia	H50.00	☐ Pinguecula 1-R 2-L 3-B	H11.15_
☐ Anisometropia	H52.31	☐ Exophoria	H50.52	☐ Presbyopia	H52.4
☐ Aphakia 1-R 2-L 3-B	H27.0_	☐ Exotropia	H50.10	☐ Pterygium 1-R 2-L 3-B	H11.00_
☐ Astigmatism 1-R 2-L 3-B	H52.20_	☐ Foreign Body, External 1-R 2-L	T15.9_XA	☐ Ptosis 1-R 2-L 3-B	H02.40_
☐ Binocular Vision Dysf. 1-R 2-L 3-B	H53.30_	☐ Glaucoma Suspect 1-R 2-L 3-B	H40.00_	☐ Visual Field Defect	H53.40
☐ Blepharitis 1-RUL 2-RLL 4-LUL 5-LLL	H01.00_	☐ Hyperopia 1-R 2-L 3-B	H52.0_	☐ Vitreous Floaters 1-R 2-L 3-B	H43.39_
☐ Blindness, Legal, R-L	H54.3	☐ Hyperphoria	H50.53	☐ Xanthelasma 1-RUL 2-RLL 4-LUL 5-LLL	H02.6_
☐ Cataract, R-L	H26.9	☐ Keratoconus 1-R 2-L 3-B	H18.60	☐ Diabetes Ret. 0-T1 1-T2	E1_.319
☐ Conjunctivitis ( )		☐ Macular Degeneration	H35.30	☐ Normal State	Z71.1
☐ Convergence Excess	H51.12	☑ Myopia 1-R 2-L 3-B	H52.1_	☐ _____	
				☐ _____	

RETURN: _____ Days _____ Weeks _____ Months

FORM 136174 R/12/15 ITEM 7534

DR. DOUG LAMBERTSON
The OPTOMETRIST At Costco
2975 RICHMOND AVENUE
STATEN ISLAND, N.Y. 10314
Telephone (718) 524-9943

DRS. SIG: _____

TAX I.D. NO. 010710081 62620

SW CNYRxPadMV885391 P Pad 7 of 20 4/7/2018 N

OFFICIAL NEW YORK STATE PRESCRIPTION 1

DOUGLAS C LAMBERTSON OD
LIC: 005006
NPI: 1043392913

2975 RICHMOND AVE STATEN ISLAND, NY 10314 (718) 982-5182

PRACTITIONER DEA NUMBER

Patient Name Hill, Richard Date 6/12/18

Address _____

City _____ State ____ Zip ____ Age 26 Sex M F

Rx One Day Acuvue Moist for Astigmatism

OD -4.00 -0.75 x 180

OS -6.50 -0.75 x 180

☐ LEP Preferred Language

Prevent medication errors. Please see back of prescription.

6/12/18

Prescriber Signature X _____

MAXIMUM DAILY DOSE (controlled substances only)

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN THE BOX BELOW

REFILLS ☐ None Refills: _____

PHARMACIST TEST AREA:

Dispense As Written

0TGCF6 46

SW CNYRxPadMV885391 P Pad 7 of 20 4/7/2018 N

OFFICIAL NEW YORK STATE PRESCRIPTION 1

DOUGLAS C LAMBERTSON OD
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City _____ State ____ Zip ____ Age 26 Sex M F

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OS -6.75 -1.00 x 180

59

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6/12/18

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PHARMACIST TEST AREA:

Dispense As Written

0TGCF6 47