Eye Specialists & Surgeons
OF NORTHERN VIRGINIA

PATIENT REGISTRATION INFORMATION

Date:_____Date of Birth:_____Age:_____SSN_____

Last Name:_____First Name:_____Middle Initial:_____Gender: ☐ Male ☐ Female

Optional: Race/ Ethnicity_____Language(s) Preferred:_____

Address:_____Apt#:_____City:_____

State:_____Zip Code:_____Home Phone:_____Cell Phone: _____

Email:_____(EMAIL AND PHONE ARE REQUIRED)

Marital Status (circle one): Single/Married/Div./Sep./Widowed Spouse's Name (if applicable): _____

Primary Care Physician:_____Phone:_____

Address:_____

Pharmacy Address:_____Phone:_____

Referred by: _____

In case of emergency, who should we contact?_____Phone:_____
Relationship to Patient:_____

☐ **WORKMAN'S COMPENSATION CARRIER**:_____Adjuster Name:_____

Address: _____ Phone:_____Claim #_____DOI: _____

PRIMARY MEDICAL INSURANCE:

Person responsible for account:_____Phone:_____

Relationship to Patient:_____Date of Birth: _____

Address (if different from patient): _____

Ins. Company:_____Ins. Company Address: _____

Subscriber ID#:_____Group #:_____Co-pay: $_____

SECONDARY MEDICAL INSURANCE:

Person responsible for account:_____Phone:_____

Relationship to Patient:_____Date of Birth: _____

Address (if different from patient): _____

Ins. Company:_____Ins. Company Address: _____

Subscriber ID#:_____Group #:_____Co-pay: $_____

DAVIS VISION INSURANCE:

Insurance Company: _____ Person responsible for account:_____

Subscriber SSN#:_____ Subscriber ID#:_____

Relationship to Patient:_____Date of Birth: _____

Address (if different from patient):_____

Employer Name: _____Employer Telephone: _____

Signature of Responsible Party:_____ **Date:**_____

Rev 10/2019

MEDICAL INFORMATION SHEET **NAME:** _____

Chief Complaint: What is the main or primary problem with your eye(s), and when did you first notice symptoms or were you told of diagnosis?

_____

_____

_____

_____

EYE History (Please circle all that apply) or circle NONE

Glaucoma	Cataract	Lazy Eye (Amblyopia)
Crossed Eyes (Strabismus)		Macular Degeneration
Retinal Detachment	Eye Injury	Eye Inflammation
Laser Surgery	Operative Surgery	Other:_____

GENERAL HEALTH (Please circle all that apply) or circle NONE

Fevers	Weight Loss	Fatigue
Sinusitis / Nasal Allergies	Hearing Loss	Dry Mouth
Angina / Chest Pain	Heart Attack	Congestive Heart Disease
Rheumatic Heart Disease	Heart Murmur	Irregular or Slow Heartbeat
High Blood Pressure	Stroke	
Shortness of Breath Asthma	Bronchitis	Emphysema
Heartburn / Ulcer Hepatitis	Diabetes	
Liver Disease	Kidney Disease	Kidney Stones

Other:_____

PAST MEDICAL HISTORY:

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____
_____
_____

Smoking History:
Do you Smoke: Yes No
If Yes: Are you trying to quit?
Yes No
If No: Are you a former smoker?
Yes No

FAMILY HISTORY (GENERAL OR EYE):

_____
_____
_____
_____

Medications (Names/dosage):

_____
_____
_____
_____
_____
_____
_____

Allergies to medication: (Name/reaction):

_____
_____
_____
_____
_____
_____
_____

Please Answer if age >65
Please circle below
Influenza vaccine: Yes No
Pneumococcal vaccine: Yes No
Shingles vaccine: Yes No

Patient Signature:_____

Date:_____

Rev 10/2019

Do you want anyone to have access to your medical record?

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to Privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change this notice from time to time, and that I may contact the practice at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The type of PHI to be restricted or limited:

_____

I give permission to discuss my medical care with the following individuals:

_____

I understand that I may revoke this consent at any time, except to the extent that you have to take action relying on this consent.

Name: Date:

Refraction & Contact lens fitting Fee Policy (MEDICAL PLANS)

What is a refraction?

Refraction is a test done to determine the refractive error of your eyes, or the need for corrective glasses and/or contact lenses. i.e. A Glasses prescription.

When do I have to pay for a refraction?

Refraction (CPT code 92015) is a non-covered service by Medicare.

As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most other insurance plans follow Medicare's rules. All these plans consider refraction a "vision" service not a "medical" service. If you have a separate vision plan please let us know.

How much do I have to pay?

You will only be charged a refraction fee if you receive a prescription for glasses or contact lenses. **Our office fee for refraction is $50. Contact lens fitting costs vary.** This is collected at the time of service in addition to any copayment your plan may require.

Patient's Name:

Signature of Patient:

Relationship to Patient:

Date:

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about the policy, please ask one of our staff members for further clarification.

- PLEASE NOTE: Effective 1/1/2019, the only medical assistance insurance plans accepted are: VA Medicaid, Anthem Healthkeepers Plus, and Optima. If any other medical assistance programs, that are not of these three that we accept, is listed as secondary to the primary insurance, patient is responsible for any leftover cost.
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
- PLEASE NOTE: We no longer bill Medical plans for refractions in accordance to CMS guidelines.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved. We attempt to verify benefits ahead of any appointment time, but it is patient's responsibility to ensure benefits and status of policy.
- Full payment is due at time of service. We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized patient responsibility at the time of service. It is your responsibility to ensure if the provider is in network or out of network.
- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send the claim for you. Therefore, self-pay our charges for your care and treatment are due at the time of service.
- Please note-Refunds for credit card transactions may be subjected to a 3% deduction fee.
- Please note – Amounts that remain outstanding for more than 90 days will be sent to a third party for collection. Balances that are forwarded to a third-party collection agency will be subject to a service fee of up to 50% of the principal balance.
- If we receive a returned check from our bank for a payment you made, you will be invoiced for the original amount of the check plus a $25 bank fee per check. The payment of the invoiced amount will be due within 10 days of invoice date. We will NOT re-submit the original declined check. All amounts remaining outstanding will incur interest and/or late fees as set forth on the invoice.
- A fee of $15 will be charged to obtain a copy of your medical records. A fee of $25 will be charged for completion of medical forms. Please allow up to 7 business days for processing.
- All plans are not the same and do not cover the same services. In the event your plan determines a service to be "not covered", you will be responsible for the complete charge.
- Some plans require a referral (i.e. HMO plans). It is your responsibility to obtain the referral for your services and to ensure it was received and correct. If a referral is not obtained or is not accurate you are responsible for any amount due.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred. Parent or Guardian must be present at the time of each appointment for the full duration of the visit.
- If during routine vision exam provider deems it necessary to perform medical testings, patient understands that medical insurance will be billed.
- We are unable to offer refunds on any services performed or any retail items.
- There is a $30 no-show fee for any in-office appointment not cancelled or rescheduled within 24 hours. If you reschedule and/or no-show more than 3 times, we will collect a deposit of $50. A non-refundable $300 no-show/ cancellation fee for procedures/surgeries within 72 hours of the procedure for non-medical reasons will apply.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I hereby state that I have listed ALL the INSURANCE COVERAGE and am aware of no other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this office of all medical coverages.

_____ _____

Name Date