Today's Date:_____

Eye Specialists & Surgeons
OF NORTHERN VIRGINIA

PATIENT REGISTRATION INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____ Age:_____ Gender:_____ Language(s) Preferred:_____

Address:_____Apt#:_____City:_____

State:_____Zip Code:_____ Email:_____

Home Phone:_____Cell Phone: _____OK to leave message? ( ) Yes ( ) No

Marital Status (circle one): Single/Married/Div./Sep./Widowed

Emergency Contact:_____ Phone:_____

Relationship to Patient:_____

Primary Care Physician:_____Phone:_____
Address:_____
Referred by: _____

PRIMARY MEDICAL INSURANCE:

Ins. Company:_____

Policy ID#:_____Group #:_____

Insurance Subscriber Name_____Phone:_____

Subscriber Date of Birth :_____Relationship to Patient: _____

SECONDARY MEDICAL INSURANCE:

Ins. Company:_____

Policy ID#:_____Group #:_____

Insurance Subscriber Name_____Phone:_____

Subscriber Date of Birth:_____Relationship to Patient: _____

REFRACTION &CONTACT LENS FITTING FEE POLICY

ESSNV provides Medical Eye Exams and Vision Eye Exams

Vision Exam vs. Medical Exam

- ***a.*** Vision Exams: includes an office visit to check vision, and/or update eyeglasses or contact lens prescriptions.
- ***b.*** Medical Exams: includes diagnosis and treatment of an eye disease or condition such as glaucoma, conjunctivitis, or cataracts.
- ***c.*** Due to insurance company restrictions, you cannot use your vision and medical insurance for a joint exam on the same day. We require patients to schedule medical and vision exams on separate days.

Please note: Medicare and other forms of insurance do not consider a refraction to be a part of a comprehensive eye exam; therefore, we cannot bill your insurance. You will only be charged a **refraction fee of $50 payable at checkout** if you wish to receive a prescription for glasses from our optometrist.

***Contact lens fitting costs vary and will be collected at the time of service.**

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

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	Liver Disease
Shortness of Breath Asthma	Bronchitis	Emphysema
Heartburn / Ulcer Hepatitis	Diabetes	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

Preferred Pharmacy: _____

Address:_____

PATIENT AGREEMENT-OFFICE & FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you, therefore, your complete understanding of our practice policies is an essential element of your care and treatment. Please ask one of our staff members should you need further clarification.

1. **Cancellations & Late Arrivals:**
   If you must cancel your appointment, we ask that you notify the office within 24 hours of your appointment so that we may offer that time to another patient. Failure to notify us may result in a $30 missed appointment fee. If you are more than 20 minutes late to your scheduled appointment, we may have no choice but to reschedule. There will be a non-refundable $400 no-show/cancellation fee for procedures/surgeries not canceled at least 72 hours in advance if non-medical reasons apply.

2. **Insurance & Patient Responsibility**
   ESSNV contracts with or accepts most insurance plans. It is YOUR RESPONSIBILITY to be aware of your insurance benefits including deductibles, copays, and any referrals required by your insurance. Full payment of patient responsibility is due at the time of service. Any balance from past visits must be paid upon check-in. All services not covered by your insurance will be your responsibility and will be billed to you. Outstanding balances must be paid within 90 days; after 90 days your account may be sent to collections and additional fees may be applied.

3. **Patients under the age of 18 (Minors)**
   We require a parent or guardian to accompany any patient under the age of 18 to all appointments. Consents and agreements must be signed by the parent or guardian. The parent/guardian will be responsible for any expenses incurred for rendered services.

4. **Workers' Compensation**
   Charges for services rendered because of a verified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier once written approval has been obtained. Patients must provide accurate and necessary information to bill the carrier.

5. **Authorization to Record/Media Release Consent**
   Please be advised that throughout your appointment, you may be photographed, interviewed, and recorded by both video and audio. With your permission, these recordings may be used for customer service, training, and marketing including the use of media such as brochures, the practice website, and/or any ESSNV managed social media platforms.
   ( )**Yes**, I consent to ( )**No**, I do not consent

6. **Completion of Medical Forms**
   A fee of $25 will be charged for the completion of medical forms (i.e., DMV vision forms). In certain instances, an office visit may be required to complete these forms; otherwise please allow up to 7 business days for processing**.**

7. **Routine Vision Exam**
   If during a routine vision exam, the provider determines it is necessary to perform additional medical tests then your medical insurance will be billed instead for these additional charges.

I have read and understood the office policies of ESSNV as outlined above and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended by the practice. I hereby state that I have listed my complete insurance coverage and am aware of no other coverage. I understand that I am responsible for any claims not paid due to negligence in informing ESSNV of my insurance.

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

PRIVACY NOTICE

Use and Disclosure of Protected Health Information

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.

Please note our Notice of Privacy Practices policy is available at the front desk and online on our website, www.essnv.com under Forms.

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 have the right to revoke this consent in writing. I understand that revoking consent only takes effect starting on the date it is revoked and moving forward. It does not affect any past actions that were taken with previous consent.

Please specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment, and other healthcare operations.

_____

Name of Authorized Person or Entity Relationship Date

_____

Name of Authorized Person or Entity Relationship Date

_____

Name of Authorized Person or Entity Relationship Date

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