



19415 Deerfield Avenue, Suite 106, Lansdowne, VA 20176

PATIENT INFORMATION

PATIENT NAME: _____ _____ LAST FIRST MIDDLE		DATE OF BIRTH: ____/____/____ _____		SSN: ____-____-____ _____	
HOME/MAILING ADDRESS (STREET, APT NUMBER):		CITY		STATE ZIP CODE	
HOME PHONE NUMBER:		IN CASE OF EMERGENCY: NAME:			
CELL PHONE NUMBER:		PHONE:			
OCCUPATION:		GENDER (PLEASE CIRCLE ONE): <i>FEMALE MALE</i>			
EMPLOYER:		WORK PHONE NUMBER:		EMPLOYER'S ADDRESS:	
HOW WERE YOU REFERRED TO US? (PLEASE CIRCLE ONE): <i>NEWSPAPER FRIEND FAMILY OTHER</i>		WHO WERE YOU REFERRED BY? NAME THE REFERRING DOCTOR:			
MINOR'S LEGAL GUARDIAN: NAME: _____ _____ DOB: ____/____/____ SSN: ____-____-____		MINOR'S LEGAL GUARDIAN: NAME: _____ _____ DOB: ____/____/____ SSN: ____-____-____			
MARITAL STATUS (PLEASE CIRCLE ONE): <i>SINGLE MARRIED SEPARATED DIVORCED</i> <i>WIDOWED</i>		EMAIL ADDRESS: _____			

INSURANCE INFORMATION

NAME OF POLICY HOLDER: _____ _____ LAST FIRST MIDDLE		DATE OF BIRTH: ____/____/____		SSN# ____-____-____	
NAME OF <u>PRIMARY</u> INSURANCE: POLICY ID: GROUP#:		NAME OF <u>SECONDARY</u> INSURANCE: POLICY ID: GROUP#			
HOME/MAILING ADDRESS OF <u>POLICY HOLDER</u>:		DO YOU HAVE VISION COVERAGE? (PLEASE CIRCLE ONE) YES NO			
HOME PHONE NUMBER OF <u>POLICY HOLDER</u>:		NAME OF VISION PLAN:			
EMPLOYER OF <u>POLICY HOLDER</u>:		RELATIONSHIP WITH PATIENT:			
EMPLOYER'S ADDRESS:		OCCUPATION OF <u>POLICY HOLDER</u>:			
EMPLOYER'S ADDRESS:		WORK PHONE NUMBER OF <u>POLICY HOLDER</u>:			

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Dulles Eye Associates to render needed treatment to the above named.
2. Permission is granted to Dulles Eye Associates to release information regarding medical treatment, rendered to the above named patient to any insurance company, employer or referring physician.
3. **Managed Health Care Plans:** I understand that if I do not have vision coverage, or I am not eligible for a vision exam, I am responsible for a referral from my primary care physician. I understand that medical exams without a referral are my financial responsibility.
4. **I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.**

PATIENT'S OR GUARDIAN'S SIGNATURE
DESK/ WITNESS SIGNATURE

_____/_____/_____
DATE

FRONT



PATIENT HISTORY FORM

Patient Name: _____

Today's Date: _____

Date of Birth: _____ / _____ / _____

Referred By: _____

REVIEW OF SYSTEMS Do you currently have any of the following problems?
--

If YES, please explain below:

• Please list any medication that you are taking, including eye drops.	€ Yes € No	
• Do you have any allergies to any medications?	€ Yes € No	
• Constitutional (Fever, weight loss, other)	€ Yes € No	
• Eyes (Glaucoma, Cataract, Lazy eyes, Retina problems, Sore throat)	€ Yes € No	
• Ear/ nose/ throat (hearing loss, sinus problems, sore throat)	€ Yes € No	
• Cardiovascular (heart problems, chest pain, irregular heart beat)	€ Yes € No	
• Respiratory (Asthma, Shortness of breath, Wheezing, Coughing)	€ Yes € No	
• Gastrointestinal (Heartburn, Abdomen Pain, Diarrhea, Vomiting)	€ Yes € No	
• Genitourinary (Urinary problems, Blood in urine)	€ Yes € No	
• Integumentary (Skin rashes, excessive dryness)	€ Yes € No	
• Musculoskeletal (muscle aches, joint pain, swollen joints)	€ Yes € No	
• Neurological (numbness, weakness, headaches, paralysis)	€ Yes € No	
• Hematological/ Lymphatic (blood disorders, Leukemia)	€ Yes € No	
• Allergic/Immunologic (hay fever, allergies)	€ Yes € No	
• Endocrine (thyroid problems)	€ Yes € No	
• Psychiatric (depression, anxiety)	€ Yes € No	

Family and Social history: Do any medical or eye disease run in your family? If yes, please note relationship to patient:

- Glaucoma:

- Do you smoke? Yes No If yes, how much? _____

- Diabetes:

- Drink Alcohol? Yes No If yes, how much? _____

- High blood pressure:

- **Macular Degeneration:** _____

- **Other**

Comments:

Physician's signature _____

Date: _____ / _____ / _____



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Name: _____

DOB: _____

Gender: Male / Female

Preferred language: English
Spanish

Race: American Indian or Alaskan Native
Asian
Black or African American
Hispanic
Native Hawaiian or Other Pacific Islander
Caucasian

Ethnicity: Hispanic or Latino
Native Hawaiian or Other Pacific Islander
Not Hispanic or Latino

Email: _____

Communication Preference: Telephone / Email / Postal



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REFRACTION SERVICE AND FEE

A refraction involves the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do not cover routine refraction or routine eye examinations (when medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examination and/or glasses please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is **\$55.00** and this is collected at the time of service, in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask, we will do our best to assist you.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of services. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

This agreement will be in effect for one year from the date of my signature.

/_____/_____
Patient Signature OR (Parent for minor)

Date



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HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to Privacy regarding my protected health information (PHI). 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 in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____ / _____ / _____



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FINANCIAL STATEMENT

Vision Plans: It is the patient's responsibility to know if he/she has a vision plan AND what company it is with.

Managed Health Care Plans: If the patient does not have vision coverage, or is not eligible for a vision exam, then the patient is responsible for a referral from the primary care physician. If a referral is not received at the time of service, the patient will be financially responsible for all the care and services rendered at the time of service.

Payment: The patient is responsible for all charges, deductible payments, co-insurance and/or co-pay payments at the time of service.

Cancellations and Missed Appointments: The patient is responsible for giving at least a 24 hour notice of any cancellation of his/her appointment. **ALL MISSED APPOINTMENTS WILL BE CHARGED \$30.**

I have read and understood the above office policies. I agree that I am financially responsible for any and all care that is not covered by my insurance policy.

PATIENT OR GUARDIAN SIGNATURE
FRONT DESK/ WITNESS SIGNATURE

_____/_____/_____
DATE