Virginia Eye Specialists, PC

Welcome to Our Office

Patient and Responsible Party Information

First name_____ MI_____ Last name_____(Jr,Sr, etc)_____Nickname _____

Address _____ Soc Sec # _____

City _____ Birthdate _____

State, Zip _____ Sex (circle) M F

Home / Work# _____ Marital Status S M D W

Employer _____ Occupation _____

Email address _____

Insurance Information **(Please present card(s) to receptionist)**

Primary Insurance Co._____ Secondary Insurance Co. _____

Policy holder _____ Policy holder _____

Relation to patient: *Self Spouse Child Other* Relation to patient: Self Spouse Child Other

Payment Information: *Please circle your method of payment* CASH CHECK CREDIT CARD

Primary Care Doctor's Name_____

Pharmacy _____

In case of emergency please notify_____Phone_____

Payment Policy: Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file for insurance payment when applicable. A charge of 1.5% per month will be added to all accounts 30 days past due. Accounts not settled within 30 days from the date of service will be subject to 1.5% interest fees per month, as well as a 33.33% collection and/or reasonable attorney fees and court costs if such action is necessary. All returned checks will be charge a $40.00 fee. ***Initial*** _____

Acknowledgment

If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to VES ***Initial*** _____

I agree that unless VES and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles. ***Initial*** _____

I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my ophthalmologist for financial or consultative purposes. ***Initial*** _____

Responsible Party (Please Print) _____ SS# _____

Responsible Party (Signature) _____ Date_____

DVC033

EYE HEALTH HISTORY

Date of Last Eye Exam

_____

Currently Wear Glasses?

_____

Currently Wear Contacts?

_____

Reason for Today's Visit:

_____

_____

_____

_____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	yes	no	family
Crossed Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or PRK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

Are you currently experiencing, or have experienced, any of the following? Circle all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

HEALTH HISTORY

Physician's Name_____ **Date of last visit** _____

Height _____ **Weight** _____

Are you pregnant or nursing? _____

Do you smoke? _____ **Have you ever smoked?** _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	yes	no	family	High Blood Pressure	yes	no	family
Allergies	yes	no	family	High Cholesterol	yes	no	family
Arthritis	yes	no	family	Kidney Disease	yes	no	family
Asthma	yes	no	family	Lupus	yes	no	family
Blood/Lymph Disorder	yes	no	family	Neurological Conditions	yes	no	family
Cancer	yes	no	family	Psychiatric Disorder	yes	no	family
Diabetes	yes	no	family	Seizures	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family	Skin Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family	Stroke	yes	no	family
Heart Disease	yes	no	family	Thyroid Dysfunction	yes	no	family

MEDICATIONS

Current Medications (prescription and over-the-counter and dosage)

_____

_____

_____

_____

ALLERGIES

Medication Drug Allergies

_____

_____

_____

_____

Virginia Eye Specialists, P.C.
3660 Boulevard, Suite K.
Colonial Heights, VA 23834

FINANCIAL POLICY

1. **Office visits fees:**
   - If you have a **specialists copay** with your insurance plan, it is due at the time of check-in.
   - If there is a **high deductible** on your insurance plan that has **NOT** been met, we will collect $150.00 towards your deductible at the time of check-in. If there is any due balance after your claim has been submitted, you will receive a bill for the remainder.
   - If your insurance plan has a **co-insurance**, we will collect your co-insurance amount at the time of check-in. If there is any due balance after your claim has been submitted, you will receive a bill for the remainder.

2. **Contact lens exams:**
   1. There is a $60.00 contact lens fit fee for a contact lens exam due at check-in. (We do **NOT** accept vision insurance)

3. **Refractions:**
   2. If you would like to obtain a copy of your glasses prescription, there is a $30.00 refraction fee due at check-in/out.

4. **Glasses:**
   3. When purchasing glasses from our office you must pay 50% of the total up front when ordering and the remainder can be paid upon glasses pick up.

5. **Forms:**
   4. Any forms that you require to be filled out by the doctor, there will be a $15.00 fee. (Including DMV forms)

6. **Medical Records:**
   5. If you would like to obtain a copy of your medical records, the fees are as follows:
      a. Search Fee: $20.00
      b. Pages 1-50 : $0.50 per page
      c. Pages 51+ : $0.25 per page

By signing this form I acknowledge that I understand and accept the terms of the Virginia Eye Specialists, P.C. Financial Policy:

Print Name:_____

Signature:_____

Today's Date:_____

OFFICE POLICIES

MISSED APPOINTMENTS:

- Unless appointment is cancelled at least 24 hours in advance, you may be charged for missed appointments at the rate of $25.00 per missed appointment. Please help us serve you better by keeping scheduled appointments.

INFORMATION UPDATES:

- Please bring your insurance card and picture ID with you to every visit to ensure correct information is on file. We also ask that you fill out an updated patient registration form annually. Please notify us immediately if you have any change in your name, phone number, address or insurance information.

INSURANCE REFERRALS:

- Patients are responsible for obtaining any authorizations or referrals needed prior to their scheduled appointment.

CELL PHONE USAGE:

- Please use cellphones outside the office door only. They may present interference with medical equipment and bother ill patients who are waiting.

DILATION:

- Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eyes and evaluate the peripheral retina. This is considered part of the eye exam and almost every new patient will get this. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reaction, such as acute-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I agree to all of the above terms and I hereby authorize Dr. Gupta (Virginia Eye Specialists, P.C.) and/or such assistants as may be designated by him to administer dilating eye drops:

Print Name:_____

Signature:_____

Today's Date:_____

Virginia Eye Specialists, PC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Virginia Eye Specialists, PC is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

a. For treatment - (examples: treatment of your eyes and related conditions)

b. For payment - (examples: for submitting claims to your Health Care Plan)

c. For health care operations - (examples: Quality assurance audits)

2. Virginia Eye Specialists, PC is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.

3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.

4. Virginia Eye Specialists, PC may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.

5. The Individual has the following rights regarding protected health information:

a. The right to request restrictions on certain disclosures of protected health information. Virginia Eye Specialists, PC is not required to agree to a requested restriction, however.

b. The right to receive confidential communications of protected health information, as applicable.

c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

d. The right to amend protected health information, as provided in the Privacy Regulation.

e. The right to receive an accounting of disclosures of protected health information.

f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Virginia Eye Specialists, PC is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

7. Virginia Eye Specialists, PC is required to abide by the terms of the Notice currently in effect.

8. Virginia Eye Specialists, PC reserves the right to change the terms of this Notice provisions will be effective for all protected health information that it maintains.

9. Virginia Eye Specialists, PC will provide individuals or patients with a revised Notice by issuing it at your next visit.

10. Individuals may complain to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

11. Virginia Eye Specialists, PC contact number for matters relating to complaints is: **(804) 243-2020**

12. This Notice is first in effect on November 1, 2010

I hereby acknowledge that I have read the Virginia Eye Specialists, PC Notice of Privacy Practices.

_____

Individual's Name

Date: _____