(276) 935-2292 / FAX (276) 935-2993

www.vaeyecareclinic.com

PATIENT REGISTRATION – PLEASE FILL IN ALL INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

SS# _____ Date of Birth _____

Referred By _____ Primary Care Physician _____ Optometrist _____

Pharmacy _____ Address _____ Phone _____

Employer _____ Phone _____

Address _____

List **all** contact inforamtion and check mark your preferred method(s)

Work Phone _____ Home Phone _____

Cell Phone _____ Test Message to Confirm Appointment _____

Email Address _____

Emergency Contact Information

Name _____ Phone _____ Relation to Patient _____

Address _____ City _____ State _____ Zip _____

Primary Insurance (Please Bring Card to the Appointment) Name of Company _____

Insured Name _____ Policy/Identification Number _____

Group Number _____

Secondary Insurance (Please Bring Card to the Appointment) Name of Company _____

Insured Name _____ Policy/Identification Number _____

Group Number _____

Responsible Party (If patient is a minor)

Name _____ SS# _____ Phone _____

Employer Name _____ Phone _____

PEDIATRIC HISTORY **(Fill out if patient is <u>under five (5) years of age</u>)**

Full term or Premature? _____ Weeks? _____

Birth Weight? _____

Has your child been diagnosed or treated for Retinopathy or Prematurity (i.e. (ROP) YES ___ NO ___

Problems with Birth? Vaginal _____ C-Section _____

Why was C-Section Performed? _____

_____

Problems with Pregnancy, Infection, Birth Defect? _____

_____

<u>Eye History</u>

Do you wear glasses for any of the following? _____ Distance _____ Reading _____Constant Wear

Do you wear contact lens? _____ YES _____ NO

If yes, please specify: _____Soft Lens _____ Hard Lens _____Gas Permeable

SOCIAL HISTORY

Do you smoke? YES _____ NO _____ *Do you drink alcohol?* YES _____ NO _____

Are you pregnant? YES _____ NO _____ *How often?*_____

REVIEW OF SYSTEMS

*Do you **currently** have any problems or have you had surgery with the following?*	***Please circle***	
Chronic fever, unexpected weigh gain or loss, fatigue	YES	NO
Ear/Nose/Throat (i.e. hearing loss, sore throat, sinus, allergies)	YES	NO
Heart, (i.e.) chest pain, irregular heartbeat, congestive heart failure, heart attack, angina, stroke)	YES	NO
Respiratory (i.e. shortness of breath, coughing, asthma, emphysema, chronic bronchitis, tuberculosis)	YES	NO
Gastrointestinal (i.e. heartburn, diarrhea, vomiting, hiatal hernia)	YES	NO
Hepatitis, diverticulitis, peptic ulcer, gallbladder trouble	YES	NO
Urinary (i.e. pain, discomfort, blood in urine, kidney stone)	YES	NO
Skin conditions (i.e. rash, excessive dryness, allergies)	YES	NO
Musculoskeletal (i.e. numbness, weakness, headache, paralysis)	YES	NO
Neurological (i.e.) swollen joints, joint pain)	YES	NO
Psychiatric (i.e. depression, anxiety, nervousness)	YES	NO

List any surgeries: _____

PLEASE RETAIN FOR YOUR RECORDS

VIRGINIA EYECARE CLINIC
FINANCIAL POLICY

Prompt Payment is Expected:

All medical services provided by Virginia Eyecare Clinic must be paid at the time the services are rendered to the patient. Our office staff will assist you in determining what portion of your bill will be your responsibility if you have insurance.

After your insurance has reimbursed Virginia Eyecare Clinic, there may be unpaid balances. Patients will receive a bill and any amount due from the patient should be paid within 30 days of receiving the statement. If there is a credit due on the statement, a refund will be mailed to you.

How can I pay?

We accept payment by cash, check, Visa, MasterCard, Discover.

Use of Collection Attorney

Failure to pay a balance due or defaulting on a payment plan may cause your account to immediately be turned over to a collection attorney. Payment due after insurance has reimbursed Virginia Eyecare Clinic is expected within thirty (30) days. Any account with a balance that exceeds thirty (30) days may be turned over for a collection attorney. Once the account is turned over to a collection attorney, payments must be made to the attorney.

Cancellations and Missed Appointments

As a courtesy to other patients requiring service, we ask that you provide notice of cancellations **twenty-four (24) business hours in advance.** Patients arriving more **than fifteen (15) minutes past their scheduled appointment tim**e will be asked to reschedule.

Self-Pay Patients

For patients who do not have insurance, we do offer a self-pay rate for services. For initial office visits you will need to be prepared to pay $88.00 for the exam upon checking in at the receptionist desk. Any return visits that include testing performed during an exam visit may not be covered by the $88.00 and will be billed to you separately. The self-pay rate will be discussed with you during the scheduling process.

Returned Checks and Fees

The patient will be responsible for any bank/collection/attorney/court fees associated with collecting a returned check.

Minor Patients

The adult accompanying a minor and the parents (or guardian of the minor) are responsible for the full payment. For unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an

Power of Attorney

For patient safety and compliance regarding patient care, we require any patient who is seen at our clinic through a Nursing Home, Rehab Center, or Assisted Living Facility to have their Power of Attorney present for their visit. Without a POA present, we will not be able to see you at your scheduled appointment date/time, and will reschedule you.

Medical Record Request and Forms Completion Policy

It is the policy of Virginia Eyecare Clinic to routinely charge a fee to cover the expense of duplication of records for the purpose of transfer outside the system and for the completion of forms requested by outside entities. The fee may include any and/or all of the following:

- Copying, including cost of supply and labor
- Postage, when the individual has requested the copies/forms to be mailed
- Preparing an explanation or summary if agreed to by the patient (separate fee if OD involved in preparing the report)

*Fees must be paid at the time the paperwork is dropped off or mailed.

- Medical Records will be a standard flat rate of $10
- DMV forms and letters will be a standard flat rate of $10
- Disability forms, FMLA, Workers Comp forms, letters that are two or more pages, and any miscellaneous forms will be a flat rate of $25
- Follow up paperwork from the original requesting company will be 50% of the original cost of the paperwork
- Requests will be processed within 7-14 business days

Refund Policy

Any refund request submitted to Virginia Eyecare Clinic requires 10-14 business days to be processed. If a refund is issued, it will be applied to any outstanding balance on a patient's chart. Credit card purchases have to be refunded to the original card that the payment was taken from.

VIRGINIA eyecare CLINIC

(276) 935-2292 / FAX (276) 935-2993

vaeyecareclinic.com

Patient Consent:

I, _____

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment, and health care operations. The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA). Privacy Policies upon request.

I give my permission for Virginia Eyecare Clinic to discuss my Personal Health Information with the following people:

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

☐ I decline to release my personal health information to anyone.

_____	_____	_____
Patient Signature	Date of Birth	Date
_____	_____	
Witness	Date	

VIRGINIA eyecare CLINIC

(276) 935-2292 / FAX (276) 935-2993

vaeyecareclinic.com

In order to stay compliant with the Centers for Medicare and Medicaid, we are asking for the following information to be completed. By obtaining this information, Virginia Eyecare Clinic can continue to improve the quality, safety, and efficiencies of our patients and ultimately reduce health disparities.

If you prefer **NOT** to supply this information, **we ask you to please mark the box and sign beneath.**

_____

Preferred Language

_____

Marital Status

_____

Gender

_____

Race

_____

Ethnicity (*This is clarifying if you are of Hispanic/Latino origin.)*

☐ I do not wish to supply information at this time.

_____ _____

Patient Name (*please print)* Date of Birth

_____ _____

Patient Signature Date

2017 FINANCIAL POLICY FOR VIRGINIA EYECARE CLINIC

By my signature below, I acknowledge that I have read and fully understand the Financial Policy of Virginia Eyecare Clinic.

Date: _____

Print Patient Name: _____

Date of Birth: _____

Signature of Patient or Patient Representative: _____

- A copy of this agreement will be supplied upon request.

Virginia Eyecare Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Please complete the following table with all your current medications.

Source of Medication List: (check all that apply

- ☐ Patient Verbal/Written
- ☐ Family Verbal/Written
- ☐ Nursing Home MAR
- ☐ Patient's Pharmacy
- ☐ Medication Bottles
- ☐ Medical Record
- ☐ Doctor's Office

Patient Name _____ **Date of Birth** _____

Drug Allergies: _____**YES** _____**NO** **Date Recorded:** _____

List drug allergies:

_____
_____

Drug Name (Prescription/Non-prescription, Herbs, Nutritional Supplements)	**Dose**	**Route**	**How many times per day?**	**Comments**
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		
		☐ By mouth ☐ Inhaled ☐ Other _____		

*****Please list additional medicine on the back of the form.**