Arlington Eye - Chesapeake Eye Care
Patient Information

Date Completed: ___________

Last Name: ___________________________ First Name: ___________________ MI: __________

Street Address: ____

City: __________________________ State: _______________________ Zip: ___________________

Social Security: ___________________________ Date of Birth: ____________________________

Email: __________________________________ Cell Phone: ______________________________

*** Note – Email is commonly used for appointment reminders, thank you for sharing*

Home Phone: _____________________________ Employment: Full Time☐ Part Time☐ None☐

Emergency Contact: ________________________ Emer. Contact Phone: ______________________

Referring Provider: _________________________ Provider Phone: ___________________________

Insurance Information / Responsible Party
If the patient is the Policy Holder / Subscriber, please mark as Self

Patient's relationship to the policy holder / responsible party: Self ☐ Spouse ☐ Parent ☐

Subscriber Last Name: _______________________ First Name: _______________________________

Street Address: ____

City: __________________________ State: _________________________ Zip: ___________________

Social Security: ____________________________ Date of Birth: ______________________________

Employer Name: ____________________________ Employer Phone: ___________________________

Employer City / State: ____

Patients must present a copy of active insurance coverage, for the plans with which we participate, in order to complete billing. Patients may receive services on a self-pay basis, or may chose to self-pay and receive documentation from the facility and personally submit to any coverage plan.

Arlington Eye Center, Inc.

Financial & HIPAA Policies

Assignment of Insurance Benefits and Release of Information:
I authorize payment directly to Arlington Eye Center, Inc. of any medical/surgical benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute or regulation.

Non-Covered Services:
I accept responsibility of paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Arlington Eye Center and the insurance carrier.

All out-of-pocket balances (co-payments, co-insurances and deductibles) are due at the time of service unless previous arrangements have been made in writing with the office. It is the Patient's/Responsible Party's duty to know what their out-of-pocket expenses will be before seeking treatment.

Payment Options:
- You may pay your out-of-pocket costs at the time of service by Check, Cash or Credit Card.
- There is a fee of fifty-five dollars ($55) for any check returned by your bank. (for any reason)

Past Due Accounts:
- If at any time you have a balance due which is more than 90 days old your account will be referred to an outside collection agency without notice.
- If we have to refer your account to a collection agency, you hereby agree to pay for all collection costs incurred.
- Furthermore, you understand that if your account is submitted to a collection agency, and thereby reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.
- We will also contact your insurance carrier, informing them of your failure to uphold your agreement with them, which at their discretion, may result in termination of your policy.

Missed Appointment Fee:
- The second time a patient does not arrive on time for an appointment or cancels with less than 24 hours notice, a missed appointment fee of seventy-five ($75) may be charged.
- This fee must be paid before a new appointment is scheduled. (barring an emergency)
- Patients with three or more missed appointments without notifying the practice in advance will be terminated from the practice.

Pre-Authorization:
- Many insurance companies, such as HMO's, require pre-authorization and/or referrals prior to obtaining specialty care.
- It is your responsibility to contact your insurer and/or primary care physician (PCP) to determine the need for a pre-authorization and/or referral.
- Failure to obtain a pre-authorization and/or referral may result in lower reimbursement or claim denial from the insurance company, in which case you will be responsible for the charges.

Forms & Medical Records:
- From time to time, various forms (including but not limited to) workman's comp, disability or DMV forms need to be completed by our staff. There is a twenty dollar ($20) clinical administrative fee to complete each form.
- There are also fees associated with the copying of medical records. ($35)

Please inquire at the front desk by requesting a Record Release Form.

By signing this agreement, you attest to having read, understood and agree to comply with all the terms and conditions contained herein.

Patient's Name: ____
Responsible Party (if patient is dependant) ____

Signature: ____ Date: _____/_____/______

MEDICAL HISTORY QUESTIONNAIRE

Date of last eye examination: ____

Reason for today's visit: ____

Eye pain **Blurred vision** **Eyelid crusting** **Flashes of light** **Floaters**

Discharge **Light sensitivity** **Double vision** **Decreased vision** **Halos**

List all current medications: (Prescription and over the counter):

1. ________________________________ **6.** ________________________________
2. ________________________________ **7.** ________________________________
3. ________________________________ **8.** ________________________________
4. ________________________________ **9.** ________________________________
5. ________________________________ **10.** ________________________________

Do you have any allergies to any medications? Yes __________ No __________

Medication **Symptom**

1. ________________________________ ________________________________
2. ________________________________ ________________________________

Please answer the following EYE HISTORY questions about YOURSELF:

Do you have any of the following eye conditions?	**YES**	**NO**	**If yes, please explain:**
CATARACTS			
GLAUCOMA			
MACULAR DEGENERATION			
"LAZY EYE" OR STRABISMUS "EYE TURN"			
RETINAL DETACHMENT			
CORNEAL DISEASE			
DRY EYES			

Please answer the following FAMILY EYE HISTORY:

FAMILY HISTORY	**YES**	**NO**	**RELATIONSHIP**
CATARACTS			
GLAUCOMA			
MACULAR DEGENERATION			
"LAZY EYE" OR STRABISMUS "EYE TURN"			
RETINAL DETACHMENT			
CORNEAL DISEASE			
DRY EYES			

Have you had any eye surgeries? YES OR NO If yes, please explain:

____

SOCIAL:

Do you drive: YES OR NO
Have you ever had a blood transfusion: YES OR NO If yes, what year__________
Do you smoke? YES OR NO If yes, how many packs per day? ____________
Do you drink alcohol? YES OR NO If yes, how many drinks per week? __________

Please answer the following MEDICAL HISTORY QUESTIONS ABOUT YOURSELF?

Do you have any of the following medical conditions?	**YES**	**NO**	**If yes, please explain**
HIGH BLOOD PRESSURE			
HEART DISEASE OR HEART CONDITIONS			
HIGH CHOLESTEROL			
STROKE			
DIABETES			
THRYOID			
AUTOIMMUNE DISORDERS			
HIV			
ASTHMA			
EAR/NOSE/THROAT CONDITIONS			
ENVIROMENTAL/SEASONAL ALLERGIES			
HEADACHES			
NEUROLOGICAL CONDITIONS			
KIDNEY CONDITIONS			
LIVER CONDITIONS OR HEPATITIS			
URINARY CONDITIONS			
BLEEDING DISORDERS			
CANCER			
ANXIETY/DEPRESSION			
OTHER:			

FAMILY HISTORY	**YES**	**NO**	**Relationship**
CANCER			
DIABETES			
HEART DISEASE			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
STROKE			

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? YES OR NO If yes, please explain:

____

____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care provider to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide minimum necessary information to only those who we fell are in need of your health care information and information about treatment, payment or health care operation, in order to provide health that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We have indirect treatment relationships with our (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, then, at some future time you may request this health care provider to refuse disclosure of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review your privacy notice to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

______________________________	______________________________	__________
PRINT NAME OF PATIENT	**SIGNATURE**	**DATE**

The Arlington Eye Center, Inc.

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

(Please read this entire notice carefully prior to signing.)

The purpose of this notice is to inform you of an eye test that may be performed on you today that is called "Refraction". We believe it is important for you to clearly understand what the purpose of this test is prior to it being performed.

Your insurance does **not** pay for all of your health care costs. Your insurance company only pays for "covered benefits." Some items and services are not considered benefits and will not be paid for.

When you receive an item or service that is not an insurance benefit, **you are fiscally responsible for it**, personally or through any other secondary insurance that you may have.

The CMS (Centers for Medicare Services) benefits guide specifically excludes this service, as **it is not considered a medical procedure, and the majority of private insurance companies follow this position.**

A refraction is the process or examination of the eyes to determine their ***best corrected vision.*** From a *standard of care* perspective, a refraction is considered a critical portion of an eye exam, for adults and especially children.
The refraction does not include a contact lens fitting, or any components of the evaluation of contact lenses; this is a separate procedure.

The charge for refraction is $55.00

By signing this form you are simply acknowledging receipt of this notice; this cannot be deferred:

____
Patient Name (printed)

____ ______________
Signature of Patient (or legal guardian) Date