Date of Completion _____/_____/_____

# Arlington Eye Center, Inc.

*Patient Information*

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt # _____

City: _____ _____ State: _____ Zip Code: _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Social Security Number _____ - _____ - _____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed

Date of Birth ____/____/____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

Employment Status: □ Full time □ Part-time □ Retired

Employer Name & Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: (_____) _____ - _____ ext _____

Student Status □ Full-time □ Part-time

***INSURANCE SUBSCRIBER/RESPONSIBLE PARTY INFORMATION***

If the patient is the Insurance Policy holder/Insurance Subscriber, please mark "self"

Patient's relationship to the policy holder/subscriber/responsible party □ Self □ Spouse □ Parent

**If spouse or parent is the Insurance Policy holder/Insurance Subscriber, please mark as such and complete all the requested information below.**

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: ____/____/____ Social Security Number: ____- ____- ____ Sex: □ Male □ Female

Street Address:
_____

City: _____ State:_____ Zip Code:
_____

Employer Name & Address:
_____

City: _____ State: _____ Zip Code:
_____

Work Phone: (_____) _____ - _____ ext. _____

Date of Completion: _____/_____/_____

# 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: _____/_____/_____

## The Arlington Eye Center, Inc.

### MEDICAL QUESTIONNAIRE

**LIST ANY OTHER BROTHER OR SISTERS SEEN AT OUR OFFICE: (PLEASE LIST NAMES)**

**_____**

**PURPOSE OF VISIT: _____**

**LIST ANY MEDICATIONS PATIENTS IS CURRENTLY TAKING:**

**_____**

**ALLERGIES TO MEDICATIONS:**

**_____**

**ALLERGIES:**

**_____**

**ANY FAMILY HISTORY OF THE FOLLOWING:**

**STRABISMUS YES NO GLAUCOMA YES NO**
**IF YES, WHO? _____ IF YES, WHO? _____**

**AMBLYOPIA? YES NO COLORBLIND YES NO**
**IF YES, WHO? _____ IF YES, WHO? _____**

**CATARACTS? YES NO OTHER EYE DISEASES YES NO**
**IF YES, WHO? _____ IF YES, WHO? _____**

**MEDICAL PROBLEMS:**

**PATIENT'S BIRTH HISTORY:**

**BIRTH WEIGHT: _____**

**PREMATURE: YES OR NO IF YES, HOW MANY WEEKS: _____**

**DID PATIENT RECEIVE OXYGEN THERAPY AT BIRTH? YES OR NO**

**DID PATIENT HAVE ANY INFECTION OR OTHER MEDICAL PROBLEMS AT BIRTH? YES OR NO**

**DID PATIENT HAVE RESPIRATORY PROBLEMS AT BIRTH? YES OR NO**

## 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**

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)

_____ _____
Patient Signature (or legal guardian)  Date

The Arlington Eye Center, Inc.

# INFORMATION ABOUT DILATION

## What are dilating eye drops?
Dilating eye drops contain medication to enlarge (dilate) the pupil of the eye.

## Why are dilating drops necessary?
A large pupil is helpful to examine the interior of the eye which is essential to diagnose and treat

eye diseases. Also, relaxing the focusing muscles by dilation of the eye allows for a more accurate determination of refractive error (need for glasses) in children.

## How long do dilating drops last?

Dilating eye drops used for examination of the eye can last from 4 to 24 hours, depending upon the strength of the drop and upon the individual patient. Pupil dilation tends to last longer in people with lighter colored eyes (irides). Children require stronger and longer lasting drops than do adults to accurately measure refractive error. Weaker drops are used for premature babies and neonates.

## What are the side effects of dilating drops?

Light sensitivity and blurry vision (especially for near tasks) may be noticed. Both side effects gradually disappear. Sun glasses are helpful after a dilated eye exam. Children can return to school, but teachers should be aware of blurred vision while reading.

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

_____

Patient Name (printed)

_____ _____

Patient Signature (or legal guardian)  Date

**The Arlinton Eye Center, Inc.**
**Melissa D. Kern, MD**
**Salma K. Chaudhri, MD**
1635 N. George Mason Drive, Ste. 100
Arlington, VA 22205
703-524-5777 Fax: 703-908-9647

## NO SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a $75 no show fee. You must give a 24 hour advanced notice to cancel appointments. Failure to do so will result in a $75 fee charged to your account.

**By signing below, I acknowledge that I have read and understand this policy.**

Signature of Patient or Parent:
_____

Patient Name (printed):
_____

Date: _____