260 Maple Ave. E Vienna, VA 22180

PATIENT'S INFORMATION

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

INSURANCE INFORMATION

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

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 Date FRONT DESK/ WITNESS SIGNATURE

METRO EYES

PATIENT HISTORY FORM

Patient's 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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Refraction Service and Fee

- Comprehensive Ophthalmology
- Cataract and Laser Surgery
- Diabetic eye Disease
- Corneal Transplant

Refraction is 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 refraction is **$ 45.00** and this is collected at the time of Services 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**

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 take action relying on this consent.

Patient's Name: ____

Signature of Patient: _____________________________________

Relationship to Patient: __________________________________

Date: _______/_______/_________

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FINANCIAL STATEMENT

Vision Plans: It is the patient's responsibility to know if 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 copay 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'S OR GUARDIAN'S SIGNATURE	Date	FRONT DESK/ WITNESS SIGNATURE