Arlington Eye Center

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: _____ Emergency Contact Phone: _____
Referring Provider: _____ Provider Phone: _____
Primary Care Provider: _____ Provider Phone: _____
Pharmacy: _____ Pharmacy 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: _____
Insurance Comp: _____ Policy #: _____
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 choose self-pay and receive documentation from the facility and personally submit to any coverage plan.
Note that refraction services may not be covered by all insurances.

FAX form to: 703-908-9647 or EMAIL form to: Arlingtonrecords@ceceye.com

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Medical History Questionnaire

Date of last eye examination: _____

Reason for today's visit: _____

Eye Pain ☐ Flashes of Light ☐ Light Sensitivity ☐ Halos ☐

Blurred Vision ☐ Floaters ☐ Double Vision ☐

Eyelid Crusting ☐ Discharge ☐ Decreased Vision ☐

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

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 ☐ No ☐ If yes, please explain: _____

_____

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Social:

Do you drive? Yes ☐ No ☐

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, what year? _____

Do you smoke? Never Smoked ☐ Former Smoker ☐ Current Smoker ☐ If yes, how many packs per day? _____

Do you drink alcohol? Yes ☐ 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	☐	☐	
Thyroid	☐	☐	
Autoimmune Disorders	☐	☐	
HIV	☐	☐	
Asthma	☐	☐	
Ear/Nose/Throat Conditions	☐	☐	
Environmental/Seasonal Allergies	☐	☐	
Headaches	☐	☐	
Neurological Conditions	☐	☐	
Kidney Conditions	☐	☐	
Liver Conditions or Hepatitis	☐	☐	
Urinary Conditions	☐	☐	
Bleeding Disorders	☐	☐	
Cancer	☐	☐	
Anxiety/Depression	☐	☐	
Other	☐	☐	

Please answer the following FAMILY MEDICAL HISTORY:

Family History	**YES**	**NO**	**Relationship:**
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Stroke	☐	☐	

Have you ever been hospitalized or had surgery? Yes ☐ No ☐ If yes, please explain: _____

_____

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Notice of Privacy Practices Consent

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Notice is available on our website, posted in the office and available to you in paper form upon request. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for “subsidized” disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices and Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- When necessary, the Practice, including all staff, may leave a voicemail message for the patient on his/her listed phone numbers, as well as on any phone numbers of people authorized to receive his/her medical information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.
- The full rights of the patient are listed in the full Notice of Privacy Practices which are available upon request.

The Practice Notice of Privacy Practices last update: January 22, 2020

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Notice of Privacy Practices Acknowledgement Form

Chesapeake Eye Care Management, LLC

I am a patient at Chesapeake Eye Care. I hereby acknowledge receipt of Chesapeake Eye Care Management's Notice of Privacy Practices.

OR

I am a parent or legal guardian of the patient. I hereby acknowledge receipt of Chesapeake Eye Care Management's Notice of Privacy Practices with respect to the patient.

Patient's Name	Date of Birth
Signature	Date

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Financial Policy

Thank you for choosing a Chesapeake Eye Care Management provider. We are committed to providing you with quality and affordable health care. We realize that the cost of health care is a concern for our patients, and we are available to discuss our professional fees at any time. The following is a statement of our Financial Policy, which you must read, agree to and sign prior to treatment. Carefully review the information and please ask if you have any questions about our fees, policies or your responsibilities.

PATIENTS WITH INSURANCE: Valid health insurance information must be provided to ensure appropriate reimbursement for your care. We ask that you present your insurance card at every visit. Patients are responsible for any pertinent deductibles, co-payments, "noncovered" services resulting from the insurance claim processing. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES: Co-payments are due at the time services are rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is a direct violation of our contract with the insurance provider. If you are unable to pay your co-payment today, your appointment will be rescheduled.

MEDICARE PATIENTS: We will file to Medicare on your behalf, and with valid and effective secondary/tertiary coverage will also forward claims directly. Patients will be responsible for any resulting coinsurance and deductibles not covered by your additional (secondary/tertiary) insurance. Patients are responsible for non-covered services/supplies under separate notice (referred to as an ABN).

REFERRALS: Valid referrals and authorizations, as required by your insurance (including worker's compensation carriers), must be received before services are rendered. Otherwise your appointment will need to be rescheduled.

WORKER'S COMPENSATION and MOTOR VEHICLE ACCIDENT: We will file a claim to W/C carriers and/or auto claims with valid information. You must obtain a claim number, phone number, contact person and name and address of the insurance carrier PRIOR to your visit. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

SELF PAY: Self pay accounts are patients without insurance coverage. You are responsible for paying 100% of the charge at the time services are rendered.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

STATEMENTS: A statement will be sent to you once it becomes patient responsibility. It is our practice to bill patients once a month. If you wish to dispute the validity of the balance, we ask that you contact us immediately. Failure to make a timely payment will result in further collection action which could include accrued interest and attorney's fees.

COLLECTION OF OUTSTANDING BALANCES: All outstanding balances will be addressed at a patient's follow-up appointment. We do ask that any outstanding balances are taken care of at that time unless discussed with either the Billing Manager or the Collections Specialist.

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FORMS COMPLETION: We do charge for completion of any forms that need to be completed by the physician. The fee will be discussed when the form is presented to the Front Desk.

CONTACT LENSES: By signing this document you are agreeing to be responsible for the overall cost of your contact lenses. Your lenses must be paid in full at the time of pick up, unless discussed and approved otherwise by the prescribing doctor, and the billing department of Chesapeake Eye Care. If using your insurance, please be aware that if your insurance denies any coverage for your contact lenses, you will be held responsible for the remaining balance.

PAYMENT METHODS: We accept payment by cash, check, Mastercard, Visa, Discover, American Express and CareCredit. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private health information for the purpose of treatment and re-imbursement for such care. In addition, I hereby authorize and assign benefits directly to Chesapeake Eye Care and Laser Center, LLC. I have read and understand the above described Practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

Patient Authorization

I authorize Chesapeake Eye Care Management Affiliate to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.

I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided when a statement is rendered.

I understand I will be responsible for any collection fees if my account is delinquent and referred to an attorney for collection purposes. Attorney's fees of 15% will be charged in addition to principal balance of the account if referred to an attorney for collection purposes. Delinquent accounts accrue interest at the rate of 1.5% per month. Ver. Date. 03.25.2019

Patient's Name	Date of Birth
Signature	Date

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Notice to All Patients

With the increasing complexity of insurance billing, we are often finding there is confusion around medical and routine insurance coverage. Routine coverage is typical for non-medical eye exams and medical insurance addresses medical related problems. Due to these misconceptions, we are asking that you inform us of all insurance lines of coverage and your intentions for the visit today. We will not change a diagnosis after it has been submitted to your insurance company. We cannot be expected to know the insurance coverage of every patient we do not base our diagnosis on the patient's insurance coverage.

To prevent erroneous denials and to help you collect from your insurance on the first filing of the claim, please clearly indicate during your exam today which insurance you are wishing to file to. In the event the exam is medically indicated, it may be necessary to change the insurance coverage to your medical plan. This is based on medical diagnosis, testing and decision making and should be received with you by your provider. If you have a concern regarding the doctor's diagnosis, please verify it upon checkout after your visit.

If you are using Routine Insurance and the physician finds a medical diagnosis, your Medical Insurance will be billed, and you may have an out-of-pocket expense.

Medical Exam Refraction and Dilation Consent

A refraction is a test that is performed during your eye exam using a phoropter. Most people that have had an eye examination remember the refraction as the part of the examination in which the doctor or technician asks, "Which lens is clearer or better – lens one or lens two, or do they appear about the same?"

This test is a necessary part of an ophthalmic examination to help determine your best possible visual acuity and to aid the physician in determining if there is a medical reason causing your symptoms. With this test, we determine whether you can be helped in any way by a new glasses prescription and the only way a new prescription can be written. This exam also indicates if any medical, optical or surgical treatment may be needed.

Most major insurance companies do not cover charges for a refraction. Medicare is one company that does not pay for this service. The fee for refraction is $55.00 and it is collected at time of service along with any co-payments, co-insurance, and/or deductibles your plan requires. These amounts are to be paid in full at the completion of your visit.

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and inability to see well at close range for a few hours. We provide free disposable sunglasses or dark sunglass inserts. After dilation, patients should wear sunglasses, be cautious when walking and going up or down stairs. It is recommended that you consider bringing a driver in case the dilation effects are bothersome while driving.

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Consent for Photography

I hereby authorize photographs to be taken for medical purposes. I agree to the use of negatives, prints, copies, or reproductions for insurance documentation, teaching and for monitoring my condition. I also consent to the photographing or videotaping of any surgical procedures deemed necessary for medical, scientific, or educational purposes, providing the pictures or descriptive text accompanying them does not reveal my identity.

Thank you for your cooperation.

Patient's Name	Date of Birth
Signature	Date

1635 N. George Mason Drive | Suite 100 | Arlington, VA 22205 | P: 703.524.5777 | F: 703.908.9647
ArlingtonEyeCenter.com