

PATIENT INFORMATION – PLEASE PRINT

Primary Insurance Policy Holder (If different from Patient): _____

Relationship to patient: _____ Policy Holders Social Security Number: _____ Date of Birth: _____

Race: American Indian/Alaska Native African American Asian Caucasian Middle Eastern Other

Preferred Language: _____

SOCIAL HISTORY

Do you currently use tobacco products? Yes No If yes, type/amount: _____ Are you a former user? Yes No

Do you currently drink alcohol? Yes No If yes, type/amount: _____

MEDICAL HISTORY

Please note any conditions (Self, Parents, Grandparents, Siblings, and Children; living or deceased):

<u>CONDITION / DISEASE</u>	Y	N	Who	<u>CONDITION / DISEASE</u>	Y	N	Who
Cancer (Constitution)				Muscles / Skeletal			
Ear/Nose/Throat				Arthritis			
Hearing				Gout			
Sinusitis				Fibromyalgia			
Neurological				Osteoporosis			
Headaches				Skin (Integumentary)			
Migraine Headache				Rosacae			
Seizures				Eczema / Psoriasis			
Multiple Sclerosis				Shingles (HZ)			
Psychiatric				Cold Sores (HS)			
Anxiety / Depression				Endocrine			
Attention Deficit / Hyperactivity				Thyroid			
Cardiovascular				Diabetes			
Stroke / CVA				Hematologic / Lymphatic			
Heart Disease				High Cholesterol			
High Blood Pressure				Anemia			
Respiratory				Allergy / Immune System			
Asthma				Rheumatoid Arthritis			
Emphysema				Lupus			
Sleep Apnea				Sjrogrens' Syndrome			
Cigarette Smoker				Environmental Allergies			
Gastrointestinal (GI)							
Crohn's Disease				Drug Allergies:			
Genitourinary (GU)							
Pregnant / Nursing							
Kidneys				Other Conditions Not Listed:			
Prostate							
Sexually Transmitted (STD)							

List any medications you take (including for the eyes, oral contraceptives, aspirin, over-the-counter medications, and home remedies): _____

EYE HISTORY

Please note any conditions (Self, Parents, Grandparents, Siblings, and Children; living or deceased):

<u>CONDITION / DISEASE</u>	Y	N	Who	<u>CONDITION / DISEASE</u>	Y	N	Who
Blindness				Glaucoma			
Cataract				"Lazy Eye" / Amblyopia			
Crossed Eyes / Eye Turn				Macular Degeneration			
Eye Surgery / Infection / Injury				Retinal Detachment / Disease			

OTHER EYE CONDITIONS NOT LISTED:

OFFICE FINANCIAL RESPONSIBILITY

- Payment in full is due at the time of service unless an arrangement has been made prior to your scheduled appointment. ***We accept cash, check, Visa, MasterCard, American Express, Discover, Care Credit, and HSA/FSA cards.***
- All checks returned by the bank for insufficient funds will incur a \$40.00 bank fee. After we notify you, you have three (3) days to remit payment in full, plus the additional \$40.00. Failure to do so will result in your account being turned over to a collection agency, you will be charged an additional collections fee of \$50.00, which will be added to the balance owed.
- Understand that should your account become past due and it is required to be placed with a collections agency, you will be charged a collections fee of \$50.00, which will be added to the balance owed.
- **We require full payment for materials (glasses and/or contact lenses) at the time the order is placed. If you cancel that order after it has been processed I will be charged a return fee of 25% of the original order amount.**
- If you require a **referral** for your medical insurance you are responsible for arriving with the referral from your Primary Care Physician (PCP) or you will be responsible for paying, in-full, for all services rendered at the time of the examination.
- Understand that all patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This contact lens medical evaluation is performed every 12- months whether or not new contact lenses are purchased. There is an additional charge for this service, called "Contact Lens Evaluation." Most medical insurance companies consider contact lenses "cosmetic" and not "medically necessary;" therefore, **services related to contact lenses are not covered and will be your responsibility.** Certain vision discount plans (VSP, Davis Vision, etc) do have benefits for contact lenses and discounts toward the contact lens medical evaluation.

If you do not wish to incur any contact lens charges, please inform our staff **before** your examination and remove your contact lenses before your examination begins. However, if this is your choice we will not be able to dispense any contact lenses to you, write a prescription for contact lenses, or be responsible for any contact lenses you might continue to wear.
- During the course of the examination, the Doctor may request further specialized tests due to medical history, family history or to better diagnose any potential eye health problems. In many cases these tests are covered by your major medical plan. If your plan should not cover the recommended testing these charges will be your responsibility and due at the time of your appointment.
- As your eye care provider it is our responsibility to provide you and your family with the best possible eye health care. Please remember, your insurance policy is an agreement arrived at between you and your insurance company and not between your insurance company and your provider (Annandale EyeCare). Each insurance company has dozens of plans; all different. It is impossible for our staff to have complete knowledge of each one.
 - ***If you plan to use your insurance as a form of payment*** you must present a current insurance ID card to our staff no later than at the time of your appointment; if your **vision plan** is not listed on your major medical insurance card you must inform us of the vision plan's name so we can research and determine your coverage. ***If you have not presented your insurance information prior to the completion of your examination we will not be able to provide refunds, order cancellations or adjustment to fees AFTER services have been rendered and/or your order for glasses and/or contact lenses have been placed.*** You may be able to file for reimbursement on your own.
 - Although we pre-authorize services and materials prior to your arrival, we are told by your insurance company that they will not guarantee payment of the claim until they have processed your individual claim. If your insurance company declines the claim submitted, you will be responsible for the balance owed.
 - If your deductible has not been met, your visit will not be covered by your insurance company and you **will** be charged today. We will file the claim with your insurance company so that the amount you paid today is credited toward your deductible amount.
 - We require any and all known co-payments be paid at the time of your visit. You may have a deductible, additional co-pay or co-insurance amount, or declined services balance due after your insurance company processes your claim. This amount will be billed to you immediately upon our receipt of your explanation of benefits (EOB). The balance owed is due within 30-days of the date the bill is sent to you.
- If there are any questions concerning your bill, either today or when received by mail, it is your responsibility to ask. If we do not hear from you we will assume that you understand, and agree to pay the charges listed.
- This office maintains your patient record for a period of 5 years from last date of patient encounter, or until a minor patient reaches the age of 18. After that time, this office may destroy your records in a manner which protects patient confidentiality.
- ***Your signature indicates that you have read, understand and agree to all of the above policies, and are responsible for payment of services rendered.***

Signature: _____ Date: _____

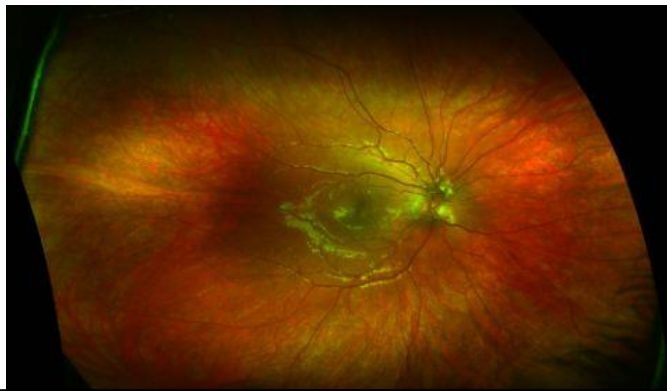
Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam™ SD - OCT retinal scan and Optomap® ultra-wide digital retinal imaging.

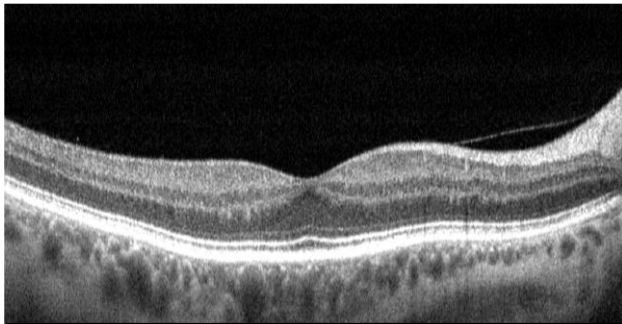
The iWellnessExam™ is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable. The Optomap utilizes scanning lasers to create a high definition image of 80-90% of the human retina. This allows the viewing of parts of the retina difficult to see under normal conditions.

As part of your pre-exam testing, our technician will perform the iWellnessExam which your doctor will review with you during your examination today. The \$49 charge is not covered by your vision or medical insurance, so this will be added to the balance of your visit. Any questions you have about iWellnessExam and the results of the test can be discussed with the doctor during your examination.

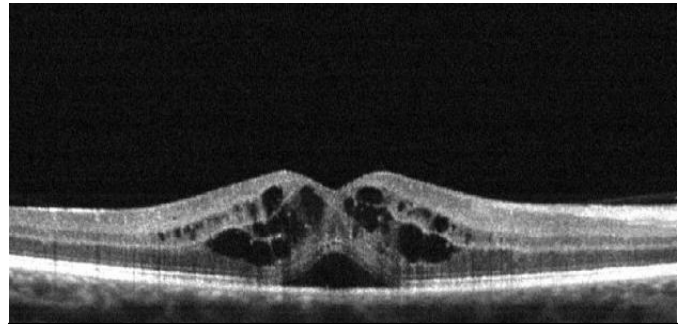
Thank you for choosing our practice to protect the health of your eyes!



Normal Wide field retinal image on the Optomap retinal exam



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam often invisible to photos and ophthalmoscopy

As part of your examination today, our Doctors need for you to have an Optos Widefield Digital photograph of your retinas and iWellness OCT Retinal Scan. These photographs help our doctors view the health of your eye and also monitor for any potentially vision threatening conditions. The digital screening photos are only \$49 and are not covered by medical insurance or vision discount plans. This charge will be added to balance of your visit.

Patient Signature _____ Date _____

(Person Responsible for the Account)