Angela Tsai, O.D., F.V.A.O.
Samuel C. Smart, O.D., F.V.A.O., F.A.A.O.
Bradley Church, O.D.
Sonia Joshi Rose, O.D.
Lauren Lombardi Schwalb, O.D.

PREMIER EYECARE

Angela Tsai, O.D. and Associates, P.C.
230 Butler Road
Fredericksburg, VA 22405
ph: 540.373.3021 fax: 540.373.5565
visionsource.fredericksburg@gmail.com

SCHEDULING FORM

Welcome to Premier Eyecare, Angela Tsai, O.D. and Associates, P.C., the office of Drs. Angela Tsai, Samuel Smart, Bradley Church, Sonia Joshi Rose, and Lauren Lombardi Schwalb.

Please fill out the following information for your upcoming eye examination. All areas are required and must be filled out. We will call you within 24 hours after receiving your information to complete your appointment scheduling. We urge you to provide a mobile phone number for notifications and reminders. Please complete the entire form. There are 4 parts to fill out. You will be done when it says "FINISHED." Bring your photo ID, insurance card, driver's license, and form of payment to your appointment. Missed appointments or those cancelled within 24 hours of the scheduled time will be assessed a $25 fee. During the months of August and December, a $50 fee will be assessed for appointments missed without a 24 hour notice.

The doctors of Premier Eyecare recommend the Optomap, a digital picture to assess ocular health of the back of the eye. If you choose to forego the Optomap, please bring sunglasses with you since the effects of dilation include glare, blurry vision, and increased sensitivity to light.

Contact lenses wearers should bring the current prescription or box of contact lenses with them as well as their eyeglasses, contact lens solution, and storage case. You will not be able to put contact lenses back on the eyes for a few hours if you choose to dilate.

We are happy to make additional appointments for family members. Comprehensive eye exams are recommended for age 6months-1 year, 3 years, 5 years, and yearly after. We thank you for choosing us to provide all your eyecare needs and services. We look forward to seeing you and your family very soon!

PLEASE EMAIL THIS FORM BACK TO FRONTDESKPREMEYECARE@GMAIL.COM
OR FAX AT 540-373-5565
AS SOON AS POSSIBLE.

PART 1

ABOUT THE PATIENT:

SALUTATION: Dr. Mr. Mrs. Ms. Miss Master [ ]New [ ] Existing patient

LAST_____FIRST _____ M___
PREFERRED/NICKNAME_____

DATE OF BIRTH (MM/DD/YYYY)_____/_____/_____

ADDRESS_____
CITY_____ STATE_____ ZIP_____

HOME PHONE (___)____-_____ DAYTIME PHONE (____)____-_____
CELL PHONE (___)____-_____ [ ] OK TEXTING (Carrier charges may apply)
EMAIL_____@_____

COMMUNICATION PREFERRENCE (SELECT ONE):
[ ] MOBILE [ ] HOME PH. [ ] EMAIL [ ] PAPER

EMPLOYER_____
OCCUPATION_____

PREFERRED LANGUAGE [ ] ENGLISH [ ]OTHER_____

ETHNICITY _____ RACE_____

PART 2

ABOUT THE GUARANTOR: The guarantor is the parent or LEGAL guardian of the patient. The guarantor is the person who will be signing the Payment Agreement.

[ ] CHECK HERE IF THE GUARANTOR AND THE PATIENT ARE THE SAME. IF THEY ARE NOT, PLEASE FILL IN SPACES BELOW.

SALUTATION: Dr. Mr. Mrs. Ms. Miss

LAST_____ FIRST _____ M___

DATE OF BIRTH (MM/DD/YYYY)_____/_____/_____

ADDRESS_____
CITY_____ STATE_____ ZIP_____

PHONE (_____)_____-_____

PART 3

PLEASE PROVIDE BOTH YOUR VISION AND MEDICAL INSURANCE INFORMATION.

VISION INSURANCE:

INSURANCE NAME_____

INSURANCE ADDRESS_____

CITY_____STATE_____ZIP_____

VISION INSURANCE PHONE (_____)_____-_____

INSURED PARTY'S NAME_____

INSURED PARTY'S ID #_____

INSURED PARTY'S GROUP #_____

RELATIONSHIP TO PATIENT_____

MEDICAL INSURANCE:

INSURANCE NAME_____

INSURANCE ADDRESS_____

CITY_____STATE_____ZIP_____

VISION INSURANCE PHONE (_____)_____-_____

INSURED PARTY'S NAME_____ _____

INSURED PARTY'S ID #_____

INSURED PARTY'S GROUP #_____

RELATIONSHIP TO PATIENT_____

I WOULD LIKE AN APPOINTMENT WITH/FOR: (CHECK ALL THAT APPLY)

[ ] DR. CHURCH [ ] DR. SMART [ ] DR. TSAI [ ] DR. JOSHI [ ] DR. L. SCHWALB
[ ] DOES NOT MATTER

[ ] MONDAY [ ] TUESDAY [ ] WEDNESDAY [ ] THURSDAY [ ] FRIDAY

[ ] 8:00-10:00 [ ] 10:00-12:00 [ ] 12:30-2:30 [ ] 2:30-4:40 [ ] 4:30-6:00 (TUES/THUR)

[ ] GLASSES [ ] CL [ ] OCULAR HEALTH [ ]SURGERY [ ] VISUAL THERAPY

Patient Name_____D.O.B.____/___/_____

Phone (_____)_____ **Cell (_____)_____**

STATUS: □ Single □Married □Divorced □Widow **Soc. Sec. #_____-_____-_____**

Occupation_____/Student

Email _____@_____._____
(Please provide your email to access the Health Portal and receive Recall notifications.)

HIPAA PRIVACY POLICY

I acknowledge I have received the notice of privacy policy.

The practice may, from time to time, contact you to provide appointment reminders, information about treatment or other health-related benefits and services. The following may be used by the Practice: a) postcard mailed to you at your address provided by you; b) email, fax, or text that may not always be secured; 3) and telephoning and leaving a message on your answering machine or with the individual answering the phone.

You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services, at the time of the services, out of your own pocket in full. This does not apply to services that are covered by insurance.

We agree to provide you your electronic protected health information (ePHI) in the format requested by you via patient portal, fax, or email, which may or may not always be secured. If it is not readily producible in the format requested, we will give you a hard copy. Any directive given to us by you to transmit health information must be done in writing, signed and clearly identifying the designated person and location to send the ePHI. We will provide your information within thirty (30) days from date of request.

All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. All questions concerning this Policy or requests made pursuant to it shall be addressed to Dr. Angela Tsai, Premier Eyecare, 230 Butler Road, Fredericksburg, VA 22405. **INITIAL_____**

MISSED APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do the best. *A scheduled appointment is a commitment of time between you and our practice.* We have reserved that time *just for you.* We ask when you schedule an appointment that you make every effort to keep that commitment. We understand personal emergencies sometimes occur and we take that into consideration when receiving a last minute cancellation. If you find you cannot keep your scheduled appointment, please contact us as soon as possible. It is our policy that with less than 24-hours notice on a change of commitment, a charge of $25.00 will be applied to your account and may be cumulative. $50.00 fee will be applied for our busiest months of August and December. **INITIAL _____**

INSURANCE

I request payment of authorized insurance benefits for any services/products furnished to me, be made in my behalf, to Premier Eyecare, Angela Tsai, O.D. and Associates, P.C. (the provider). I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine the benefit(s) payable for related services/products. **I understand I am responsible for charges not paid by my insurance plan and payment is expected at time of service.**

Signature_____**Date**____/___/____

Patient Name_____

PAYMENT AGREEMENT

I hereby agree to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services/products are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If there is failure to promptly pay for the services/products rendered, I authorize the release by or to any credit reporting agencies of personal credit information and further agree to pay all costs of obtaining such credit information. All products must be paid in full at time of delivery.

I understand Medical/Vision Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if I promptly furnishes the provider with all correct insurance information. I am fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, I understand medical, personal and financial records concerning professional services/products will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

Signature_____**Date**____/___/____

RELEASE OF INFORMATION

I give my permission for Premier Eyecare, Angela Tsai, O.D. and Associates, P.C. to release/dispense my medical records, insurance information, billing statements, prescriptions, contact lens, and/or eyeglasses to the following person(s) listed below. I understand that it is my responsibility to follow-up with the person(s) listed below to receive the reports or item. I understand the provider is not responsible for loss, stolen, or misuse of information or items released to the person(s) listed below.

I understand if my records are subpoenaed by law, that the provider must furnish medical reports and billing. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services, at the time of the services, out of your own pocket in full. This does not apply to services that are covered by insurance.

Release to: (This includes, but is not limited to, spouses, parents, schools, or other health care professionals.)

(1)_____ Relationship _____

(2)_____Relationship_____

OPTOMAP

Your insurance is designed to cover a basic or wellness eye exam. It does not cover advanced screening tools such as the Optomap. The doctors would like for all their patients to have an Optomap screening annually to aid in the detection of disease in the back of the eye. Screenings are $45.

In some cases, your doctor is required to dilate the eye(s) as well, including, but not limited to diabetes, macular degeneration, flashes, floaters, and ocular trauma. If a medical diagnosis is found on the Optomap screening, you may elect to have it sent to your medical insurance for possible coverage. Many insurances cover retinal photography, but I understand that if my medical insurance does not, I will be responsible for the charges. An Advanced Beneficiary Notice will be provided. Your Doctor prefers Optomap to keep a history of your ocular health.

Please Circle: Optomap Dilation INITIAL _____

MEDICATIONS

Please list all medications, including over-the-counter medications and supplements.

MEDICATION NAME	STRENGTH (mg/mL)	DOSAGE (Once/twice per day)	REASON FOR MEDICATION

Pharmacy Name _____Phone Number (____)____-_____

Pharmacy Address_____

Primary Care Physician_____ Phone Number (____)____-_____

Medication
Allergies_____

GENERAL

Height____ft____inches Weight_____lbs

Do you drink?	Yes	No
Do you smoke?	Yes	No
Do you do recreational drugs?	Yes	No
Have you had a blood transfusion?	Yes	No
Do you have any HIV/AIDS or STDs?	Yes	No

OCULAR HISTORY

Please check if you or an immediate family member have or had issues in any of the following areas:

	Self	Mother	Father	Sibling	PGF	PGM	MGF	MGM
Blindness	□	□	□	□	□	□	□	□
Cataracts	□	□	□	□	□	□	□	□
Color Issues	□	□	□	□	□	□	□	□
Floaters	□	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□	□
Lazy Eye	□	□	□	□	□	□	□	□
Ocular Cancer	□	□	□	□	□	□	□	□
Retinal Detachment	□	□	□	□	□	□	□	□

Other_____

Ocular Surgeries for Patient_____

REVIEW OF SYSTEMS

Please check if you or an immediate family member have or had issues in any of the following areas:

	Self	Mother	Father	Sibling	PGF	PGM	MGF	MGM
Arthritis	□	□	□	□	□	□	□	□
Autoimmune Disorder	□	□	□	□	□	□	□	□
Blood Problems	□	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□	□
Cardiovascular	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Digestive	□	□	□	□	□	□	□	□
Ear, Nose, Throat	□	□	□	□	□	□	□	□
Current Fatigue	□	□	□	□	□	□	□	□
Current Fever	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□
Immunological	□	□	□	□	□	□	□	□

Kidney	□	□	□	□	□	□	□	□
Liver	□	□	□	□	□	□	□	□
Musculoskeletal	□	□	□	□	□	□	□	□
Neurological	□	□	□	□	□	□	□	□
Psychiatric	□	□	□	□	□	□	□	□
Skin	□	□	□	□	□	□	□	□
Thyroid Issues	□	□	□	□	□	□	□	□
Urinary	□	□	□	□	□	□	□	□
Weight Loss	□	□	□	□	□	□	□	□

Allergies

Do you wear contact lenses? □ Yes □ No
Are you interested in contact lenses? □ Yes □ No

Do you have any night vision issues? □ Yes □ No

Do you have dry eye? □ Yes □ No
Would you like dry eye testing? □ Yes □ No

Do you work on a computer/tablet/cell phone more than 1 hour a day? □ Yes □ No
Are you eyes fatigued at the end of the day? □ Yes □ No

Do you have prescription sunglasses? □ Yes □ No

Are you here for a visual therapy evaluation? □ Yes □ No

Signature_____Date____/___/___

Print_____Relationship_____

Patient/Legal Guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION.
PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations**. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information**. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information**. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.
- **To receive an accounting of disclosures of your health information**. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information**. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Name: _____

Address: _____

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: May 17, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Angela Tsai, O.D. & Associates, P.C., Notice of Privacy Practices.

Date _____ Patient name _____ Signature _____