Patient Name_____M/F D.O.B.___/___/_____

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

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

Insurance Name_____ Group Policy #_____

Guarantor_____ Subscriber_____

Occupation_____/Student Work Place_____

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

HIPAA 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 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 questions and requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer," Dr. Angela Tsai, Premier Eyecare, 230 Butler Road, Fredericksburg, VA 22405. I acknowledge I have been offer the notice of privacy policy. **INITIAL_____**

MISSED APPOINTMENT/AFTER NORMAL HOURS 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 understand personal emergencies sometimes occur. 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. Appointments requested for 6:00pm or after and after-hour visits will occur an additional charge. **INITIAL _____**

PAYMENT AND INSURANCE 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 services/products must be paid in full at time of delivery. I understand refund and exchange policies are posted.

Patient Name_____

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."

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**____/___/____

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 covered by insurance. Please 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. **Circle one: Optomap Dilation**
INITIAL _____

MEDICAL AND MEDICATION RECONCILIATION

What brings you in today?_____

Primary care physician _____ **Phone**_____

Pharmacy Name/Location_____ **Phone**_____

I allow my optometrist to send/receive information from my pharmacies provided _____Initial

Patient Name_____

Are you on any high risk medications? Treating Specialist_____
The following are examples:

Amiodarone Chemotherapy Flomax Methotrexate Hydroxychloroquine Plaquenil
Prednisone Tamoxifen Topamax Tricyclic Antidepressants Vitamin A

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

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

Allergies (Medication/Dyes/Latex)_____

Height____ft____inches **Weight**_____lbs

Do you drink? Yes No #of drinks____ per day
Do you smoke? Yes No Packs____ per day Quit/When_____
Do you do recreational drugs? Yes No
Have you had a blood transfusion? Yes No

REVIEW OF SYSTEMS

Please circle if you are experiencing any of these TODAY:

Poor vision	Jaw pain	Chills	Ear ache	Rapid heart beat	Rash
Eye pain	Scalp tenderness	Weight loss	Cough	Elevated blood pressure	Anemia
Tearing	Loss of vision	Dry mouth	Wheezing	Shortness of breath	Bleeding issues
Redness	Fever	Stuffy nose	Congestion	Allergies	
Upset stomach	Urinary frequency	Arthritis	Seizures	Depression	
Diarrhea	Burning on urination	Rash	Stroke	Insomnia	
Constipation	Incontinence	Changing moles	Paralysis	Elevated Glucose	
Stiffness	Join pain	Headache	Anxiety	Thyroid Abnormalities	

Patient Name_____

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
Amblyopia	□	□	□	□	□	□	□	□
Blepharitis	□	□	□	□	□	□	□	□
Blindness	□	□	□	□	□	□	□	□
Cataracts	□	□	□	□	□	□	□	□
Color issues	□	□	□	□	□	□	□	□
Corneal dystrophy	□	□	□	□	□	□	□	□
Diabetic retinopathy	□	□	□	□	□	□	□	□
Dry eye	□	□	□	□	□	□	□	□
Floaters	□	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□	□
High Prescription	□	□	□	□	□	□	□	□
Iritis/Uveitis	□	□	□	□	□	□	□	□
Lazy eye/Strabismus	□	□	□	□	□	□	□	□
Macular degeneration	□	□	□	□	□	□	□	□
Macular pucker/ERM	□	□	□	□	□	□	□	□
Narrow angles	□	□	□	□	□	□	□	□
Ocular allergies	□	□	□	□	□	□	□	□
Ocular cancer/Tumor	□	□	□	□	□	□	□	□
Ocular hypertension	□	□	□	□	□	□	□	□
Ophthalmic migraine	□	□	□	□	□	□	□	□
Retinal tear	□	□	□	□	□	□	□	□

Other_____

Ocular Surgeries for Patient_____

MEDICAL 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
Arthritis	□	□	□	□	□	□	□	□
Autoimmune Disorder	□	□	□	□	□	□	□	□
Blood Problems	□	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□	□
Cardiovascular	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Hepatitis_____	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
HIV/AIDS	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□
Kidney	□	□	□	□	□	□	□	□
Liver	□	□	□	□	□	□	□	□
Musculoskeletal	□	□	□	□	□	□	□	□
Neurological	□	□	□	□	□	□	□	□
Psychiatric	□	□	□	□	□	□	□	□
Skin	□	□	□	□	□	□	□	□
Thyroid Issues	□	□	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□	□	□

Patient Name_____

Do you wear contact lenses?	□ Yes	□ No
Are you interested in contact lenses?	□ Yes	□ No
Do you have any night vision issues?	□ Yes	□ No
Would you like to have night vision testing?	□ Yes	□ No
Do you have dry eye?	□ Yes	□ No
Would you like dry eye testing?	□ Yes	□ No
Would you like macular degeneration early detection screening?	□ Yes	□ No
Do you work on a computer/tablet/cell phone more than 1 hour a day?	□ Yes	□ No
Are your 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

- -

OFFICE USE ONLY

Reviewed by _____Technician _____Doctor Date_____

Received electronically Received by_____

Kiosk	□ Yes	□ No
Portal	□ Yes	□ No
Website	□ Yes	□ No

Notes: