

Last, First, M. \_\_\_\_\_ M/F D.O.B. \_\_\_ / \_\_\_ / \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

What brings you in today? Are you having any visual issues? Please explain. \_\_\_\_\_

Primary care physician \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy Name/Location \_\_\_\_\_ Phone \_\_\_\_\_

I allow my optometrist to send/receive information from my pharmacies provided. INITIAL \_\_\_\_\_

Allergies (Medication/Dyes/Latex) \_\_\_\_\_

**MEDICATIONS: Please bring a copy of your medication list with you to your appointment. Include the name, strength, dosage, frequency and reason of use of each medication.**

Height \_\_\_ ft \_\_\_ inches Weight \_\_\_\_\_ lbs

Are you diabetic?  Yes  No  
Circle: Type 1 2 HbA1c \_\_\_\_\_ FBS \_\_\_\_\_ Treating Physician \_\_\_\_\_

Are you on a high risk medication  Yes  No  
Ex. Hydroxychloroquine, Plaquenil, Tamoxifen Treating Physician \_\_\_\_\_

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? (age 50+)  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

### 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, ocular trauma, and post surgery. 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 \_\_\_\_\_

## **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 time of July 15<sup>th</sup>-August 15<sup>th</sup> and the month of 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. 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.** INITIAL \_\_\_\_\_

### 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 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print \_\_\_\_\_ Relationship \_\_\_\_\_

**Patient(self)/Legal Guardian**

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**OFFICE USE ONLY**

Reviewed by \_\_\_\_\_ Technician                      \_\_\_\_\_ Doctor                      Date \_\_\_\_\_

Received electronically

- |         |                          |     |                          |    |
|---------|--------------------------|-----|--------------------------|----|
| Kiosk   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Portal  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Website | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Received by \_\_\_\_\_