Patient History Form

Name:	AGE:
Referred By:	SCANNED

Occupation: **New Family Doctor:**

1. Please list medications you are taking, including eye drops. **Has to be filled out**	**1.**		**8.**		
	2.		**9.**		
	3.		**10.**		
	4.		**11.**		
	5.		**12.**		
	6.		**13.**		
	7.		**14.**		

		If yes, please explain
2. Do you have any allergies to any medication?	Yes No	
3. Constitutional (Fever, weight loss, other)	Yes No	
4. Eyes (Glaucoma, cataract, lazy eye, retina problems, Other-please specify) Please check √	Yes No	**Blurred vision** **Light sensitive** **Double vision** **Headache** **Flashes/Floaters** **Itchy eyes** **Dry eyes** **Red eyes** **Discharge** **Pain** **Other (list all eye surgeries):**
5. Ear/nose/mouth/throat (Hearing loss, sinus problems, sore throat)	Yes No	Sinusitis Hearing loss Nose bleeds Dry mouth
6. Cardiovascular (Heart problems, chest pain, irregular heart beat)	Yes No	High blood pressure Heart attack Angina Heart Failure
7. Respiratory (Asthma, shortness of breath, wheezing, coughing)	Yes No	
8. Gastrointestinal (Heartburn, abd. pain, diarrhea, vomiting)	Yes No	
9. Genitourinary (Urinary problems, blood in urine)	Yes No	
10. Integument (Skin rashes, excessive dryness)	Yes No	
11. Musculoskeletal (Muscle aches, joint pain, swollen joints)	Yes No	
12. Neurological (Numbness, weakness, headaches, paralysis)	Yes No	
13. Hematologic/Lymphatic (Blood disorders, leukemia)	Yes No	
14. Allergic/Immunologic (Hay fever, allergies)	Yes No	
15. Endocrine (Thyroid problems)	Yes No	**Diabetes** **Year Diagnosed:** Thyroid
16. Psychiatric (Depression, anxiety)	Yes No	

Family and social history: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

Glaucoma	**Smoking**	**Yes**	**NO**
Macular degeneration	**No. of packs per day**		
Diabetes			
High blood pressure	**Alcohol consumption**	**Yes**	**NO**
Comments:	**How much**		

Dr. Initials

Email:

PATIENT REGISTRATION

SCANNED

	FIRST NAME:	MI:	LAST NAME:

SOCIAL SECURITY NO:	DATE OF BIRTH:
Primary Care Doctor:	Preferred method of contact: ☐ TEXT ☐ EMAIL ☐ CALL CELL ☐ CALL HOME
CELL PHONE:	HOME PHONE:

ADDRESS: NO.:

CITY: STATE: ZIP:

SEX: M F PREFERRED LANGUAGE:

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ORIGINS ☐ UNKNOWN ☐ DECLINE TO FURNISH INFORMATION

RACE:	☐ AMERICAN INDIAN	☐ ASIAN	☐ BLACK	☐ NATIVE HAWAIIAN	☐ UNKNOWN	☐ WHITE

SMOKING STATUS	☐ EVERYDAY SMOKER	☐ SOMEDAY SMOKER	☐ SMOKER UNKNOWN STATUS
	☐ FORMER SMOKER	☐ NEVER SMOKER	☐ UNKNOWN

PERSONS TO CONTACT IN CASE OF EMERGENCY:	RELATIONSHIP	TEL. NUMBER

EMPLOYER: BUSINESS PHONE: NAME OF SUPERVISOR:

EMPLOYER ADDRESS: CITY: STATE: ZIP:

FINANCIAL INFORMATION:

Name of responsible person: Last First MI Social Security No.

ADDRESS: CITY: STATE: ZIP

HOME PHONE: BUSINESS PHONE:

PRIMARY INSURANCE: ID/POLICY NO. GROUP NO.

ADDRESS:

SECONDARY INSURANCE: ID/POLICY NO. GROUP NO.

ADDRESS:

SIGNATURE OF RESPONSIBLE PARTY DATE

LOUDOUN MEDICAL GROUP, P.C.
&
NEW VISION, THE EYE CENTER, LLC

HIPAA PATIENT CONSENT FORM
FOR: FNAME LNAME

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 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, 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 treatment, payment and health care operations. 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 your 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
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- 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.**

This Consent was signed by: Date:

Printed Name – Patient or representative Relationship to Patient (if other than patient):

Authorized person(s) to receive health information	1.
2.	3.

In front of

PREFERRED PHARMACY INFORMATION:

PHARMACY NAME	
STREET	
CITY	
STATE	

PLEASE NOTE ADDITIONAL CHARGES NOT COVERED BY MOST INSURANCE PLANS:

- **Refraction: an integral part of the eye exam. It allows the doctor to determine if the blurred vision is related to a needed change in the eyeglass or contact lens prescription or related to a condition such as dry eye or cataracts etc…. It has to be performed to allow the doctor to determine the severity of some disease states. If declined the eye exam may not be complete or may be terminated.**
- **Routine eye exams for a simple eyeglass evaluation may not be covered by many insurance plans. If you have such coverage please inform the staff prior to the exam. No charges will be reversed after the completion of the exam.**
- **Contact lens fitting and prescription is not covered by most health insurance plans. It is paid by the patient or the responsible party at the completion of the eye exam. No contact lens prescription will be released without full payment of the fitting fees. Fees range from $95 to over $600 depending on the complexity of the fit. All follow up appointments must be completed prior to the release of any prescription. Additional fees may apply for additional visits.**
- **Retinal scans for screening are not covered by insurance. This allows the practice to keep a record of the retinal status including the nerve blood vessels and overall health for future comparisons.**
- **Forms needed by the patient will be charged a minimum of $40 or more depending the time needed for completion by the doctor. Please allow for 5 working days, unless the doctor is on vacation. We will attempt to assist as much as possible. Some DMV forms require a more complex evaluation prior to completion. An additional visit(s) may be needed prior to completion.**
- **After hours prescription refills will be charged at $45 per call, except for surgical patients.**
- **Missed appointments will be charged a fee if not canceled at least 12 hours prior to the appointment, except for emergency cases.**
- **If you have a financial hardship, please inform your doctor and arrangements can be made to assist you with the exam.**

ASSIGNMENT AUTHORIZATION/ RELEASE OF INFORMATION:

I, the undersigned, hereby authorize The Eye Center, its physicians and/or agents to apply for benefits on my behalf for services rendered to me. I request payment from my insurance carrier to be made directly to **LOUDOUN MEDICAL GROUP, P.C.** I certify that the above information is correct and further authorize the release of any information for any claim to my insurance carrier. I understand the HIPPA compliance regulations and agree to them. I also authorize The Eye Center, its physicians and agents to disclose any part of or all of the medical records to my insurance carrier. I agree that The Eye Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I also understand that it may be necessary to contact my present or past employer (s) in regard to insurance claims.

GUARANTEE OF PAYMENT/ NON-COVERED CHARGES:

I, the undersigned, understand that I am financially responsible for all charges including those not covered by my health insurance and /or Medicare. I further understand that Medicare and/ or my health insurance company may not cover all services rendered, such as **refractions, routine eye exams, eye glasses and other ancillary testing**, including the **optomap retinal scan**. Charges for these services may be obtained prior to the examination. I understand if Medicare and/or my insurance company deny services, then it will be my responsibility to pay for these charges. In the event that the account must be placed with an attorney or a collection agency, I agree to pay 33% attorney fees, 40% collection cost and interest on the unpaid balance of 18% per annum. Medical records are maintained electronically for a minimum of seven years or longer as required by law.

$40.00 may be charged for not canceling the appointment at least 12 hours prior to the time of the visit.

SIGNATURE OF RESPONSIBLE PARTY **DATE** **WITNESS**