Patient Registration Information Date: _____

Patients First Name_____ Middle Initial _____ Last Name _____

How would you like our staff to address you? _____

Date of Birth _____/_____/_____ Age _____ Sex_____

Mailing Address_____ City_____ State____ Zip _____

If different, full street address_____City_____ State_____ Zip _____

Home Phone ( )_____-_____ Cell Phone ( )_____-_____

Best Time to Call _____Email Address _____

SSN _____/_____/_____Marital Status _____

Preferred Language:_____ Race:_____

Ethnicity:_____

Preferred Pharmacy _____ City/State _____

How did you hear about us?_____

PCP/Medical Doctor:_____

Employer_____ Phone ( ) _____ - _____

Full Time, Part Time Occupation or school name_____

Emergency contact name: _____Relationship to Patient_____Phone( )_____-_____

Responsible Party's Name _____ Date of Birth ____ /____ /_____ Age ____ Sex____

If different address from patient, please provide information below.

Address_____ City_____ State_____ Zip _____

Home Phone ( )_____-_____ Cell Phone ( )_____-_____

Employer _____ SSN _____

Full Time/ Part Time Occupation / Retired _____

Primary Insurance _____ Primary Insured name_____

Primary Insured date of birth_____Primary Insured SSN_____

Group #_____ID_____

Secondary Insurance _____ Secondary Insured name_____

Secondary Insured date of birth_____Secondary Insured SSN_____

Group #_____ID_____

Relationship of patient to the policyholder: SELF SPOUSE PARTNER CHILD OTHER (please circle answer)

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Ocular History: (please circle all that apply)

Allergic conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal dystrophy (Left eye, Right eye)
Diabetic retinopathy, background (Left eye, Right eye)
Dry eyes
Glaucoma (Left eye, Right eye)
Macular degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow angles (Left eye, Right eye)
Ocular hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitrous floaters (Left eye, Right eye)
None
Other _____

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left eye, Right eye)
Cataract surgery (Left eye, Right eye)
Corneal transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Renital laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
Yag capsulotomy (Left eye, Right eye)
None
Other _____

Family History: (please circle all that apply—which family member)

Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Heart disease
Macular degeneration
Migraine
Retinal detachment
Strabismus
None
Other _____

ARE YOU UNDER HOSPICE CARE AT THIS TIME? _____

Medications: (Please list all current medications with dosage and frequency)

None

Allergies: (Please enter all allergies)

None

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Other_____

None

I hereby authorize Eye Care Physicians & Surgeons, PC to apply benefits on my behalf for covered Services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information including material information for this or any related claim to my insurance carrier. I assign to Eye Care Physicians & Surgeons, PC any and all benefits incurred for the services provided by them and any other further services. I understand I am financially responsible for charges not covered by my insurance. This includes payment of any deductible amount and/or any unpaid balance after payment by my insurance carrier(s). I accept responsibility for payment in full service provided by Eye Care Physicians & Surgeon, PC not paid by my insurance within (30) days of receiving services. In the event I do not meet my financial responsibility with Eye Care Physicians & Surgeons, PC, I agree to pay cost for collection, including attorney's fees at 50% plus court and interest.

Patient's Signature: _____ Date : _____

HMO OR PPO PATIENTS

If any services are performed in our office and prior authorizations have been obtained, I am responsible for any deductions or co-pays that are generated from their out of network benefits.

Patient's Signature: _____ Date : _____

General Informed Consent

I authorize the staff of Eye Care Physicians & Surgeons, PC to carry out all procedures ordered by my physician. I request outpatient treatment from professionals at Eye Care Physicians & Surgeons, PC and consent to all: diagnostic evaluations, therapy services, diagnostic tests, medications and/or treatments that are ordered or preferred by these professionals in their judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion, or handicap. At any time while on the premises of Eye Care Physicians & Surgeon, PC in the event of an emergency, I authorize Eye Care Physicians & Surgeons, PC or their employees to provide or obtain such medical treatment as may be deemed advisable under the circumstances. I consent to the release of my records for the purpose of billing, treatment and healthcare operations which may include but are not limited to review by the authorized representatives of my insurance carriers the review the review of my records or any necessary audits within Eye Care Physicians & Surgeons, PC, and for summary information to be released to referral sources. I understand that my records are the property of Eye Care Physicians & Surgeons, PC.

P**atient's Signature: _____ Date : _____**

PRACTICE INFORMATION/HIPAA

I was given the Notice of Privacy Practices along with the Practice Information Sheet.

Patient's Signature: _____ Date : _____

Eye Care Physicians & Surgeons, PC Date: _____

Witness: _____

EYE CARE
Physicians & Surgeons PC

103 W. South Street
Woodstock, VA 22664

158 Front Royal Pike Suite 300
Winchester, VA 22602

Phone: (540)409-5254
Fax: (540)409-5253

Financial Policy

(initial) _____ We make every effort to provide prompt medical care to each of our patients. Effective, January 1st, 2024, if you are unable to keep your scheduled appointment, a 24-hour notice to cancel the appointment is required. If proper notification is NOT received within 24 hours, I understand I will be charged a "no-show" fee of $75.00. This pertains to any and all appointments.

(initial) _____ If there is an identified pattern of no-shows, defined as three (3) or more consecutive times within one (1) year, I understand that I will be discharged from the practice.

(initial) _____ It is our intention to maintain all patient accounts in our office. However, if your account becomes past due, the office will take the necessary steps to collect this debt. In the event your account is turned over to our collection agency, collection fees will be added to your balance. I understand I will be responsible for all collection fees, up to 50% of my total account balance.

(initial) _____ If payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF) or Account Closed (AC), I understand I will be responsible for the original check amount and an additional $35.00 service charge.

(initial) _____ As of January 1st 2025, we are no longer able to bill any form of Medicaid, meaning any new or existing patient that has Medicaid will require to be self pay or find a new provider.

(initial) _____ Any patient that has a Dual Complete Medical Plan; we are able to accept and bill Medicare but we are unable to bill the remaining amount to Medicaid. ECPS will write off whatever the remaining amount is, except for if there is a refraction or no-show fee.

New Patient Emergencies: If an appointment is fit within the week of an emergency referral from either the ER or another provider, & Dr. Hynes is not on call for Valley Health, an additional fee of $50.00 will be charged at time of visit on top of charges occurred during visit.

*All fees/charges quoted above are subject to change at any time, and without prior notification. Regardless of insurance coverage (in network or out of network) patients will still be accountable for any bills received from Eye Care Physicians and Surgeons.

_____ _____

Patient Signature **Date**

HIPAA PATIENT NOTIFICATION RECEIPT AND FAMILY ACCESS TO PROTECTED HEALTH INFORMATION

Patient full name: _____ Today's date: _____

Patient date of birth ____/____/_____

PATIENT NOTIFICATION RECEIPT

I understand that part of my healthcare, Eye Care Physicians & Surgeons, PC originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among the many health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided: and a tool for routine health care operations such as quality assurance, audits and assessments.

I have been provided with the **HIPAA Notice of Information Practices** that provides a complete description of Protective Health Information uses and disclosures. I understand that I have the right to complain, consent, object, restrict and/or request correction or amendment of my Protected Health Information. I understand that all such requests must be in writing and that Eye Care Physicians & Surgeons, PC is not required to agree to any corrections or restrictions that I may request. I understand that I may revoke any consent that I may have given, in writing, except to the extent that Eye Care Physicians & Surgeons, PC has already taken action in reliance thereon.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

I hereby give permission to the person(s) listed to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share date of birth.

Name	**Relationship**	**Phone #**
Name	**Relationship**	**Phone #**
Name	**Relationship**	**Phone #**
Name	**Relationship**	**Phone #**

In addition:

With this authorization, Eye Care Physicians & Surgeons, PC may call home or other designated location and leave a voice mail message, in person or by mail in reference to appointment, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

By signing this form, I am authorizing Eye Care Physicians & Surgeons, PC to use and disclose my Protected Health Information to the individuals I have listed on previous page to act on my behalf for healthcare information.

For specific information, I am aware I will need to complete the **Consent to Release Protected Health Information form**, prior to information being released, as specified in the HIPAA Notice of Information Practices.

I may revoke this authorization in writing at any time.

PRINT NAME _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____DATE_____

EYE CARE

Physicians & Surgeons PC

Starting January 01, 2025

All refraction tests will be charged at time of visit. Regardless of insurance coverage.

Refraction is the process of determining the eye's refractive error, or need for corrective Spectacles **(GLASSES).** It is an essential part of an eye examination and is necessary for certain diagnoses.

Our office's Refraction fee is ***$45.00***. This fee is collected in addition to any co-payment at time of service. This fee **WILL** be submitted to your insurance company. If your insurance company covers this fee in any part; ECPS will then reimburse patients based off of how much of the fee your insurance covers. Most often insurance companies will not cover this fee in full, therefore it is the patient's responsibility.

All patients will receive a prescription every time a refraction is completed.

It will be the **PATIENTS'** responsibility for total payment which is collected at the time of visit**. If you are a Medicare patient, you MUST complete an Advanced Beneficiary Notice of NON-coverage (ABN) prior to service.** *If you wish to get a prescription for eyeglasses done today, YOU MUST HAVE A REFRACTION COMPLETED.*

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction fee will be collected at the time of service and then submitted to my insurance company. If my insurance company reimburses ECPS then I will be issued a refund for the same amount that was covered by insurance. I accept full financial responsibility for the cost of this service if not covered by my insurance company. The co-payment is separate from and not included in the refraction fee. A refraction will only be done if the patient requests for it to be done or if it is medically necessary for my appointment. If I choose to decline a refraction and it is required for a diagnosis, I understand that my visit may be canceled at that point and time.

Patient Name _____ Date: _____

Patients Signature (Parent for minor)

_____