PATIENT INFORMATION

Patient Name:_____ Age:_____
LAST FIRST MI

Patient Address:_____ City: _____ State:_____Zip:_____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ -_____

Date of Birth: _____ / _____ / _____ Sex: ☐M ☐F Social Security# _____-_____-_____
MONTH / DAY / YEAR

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Email address _____

Name of Responsible Party: (☐self)_____ Relationship to patient:_____

REFERRED BY: ☐ Doctor :_____ ☐Insurance ☐Friend/Family ☐Yellowpages
☐Internet ☐ ER ☐Urgent Care ☐Lecture ☐ Daleel ☐ Flyer ☐ Other_____

Preferred Pharmacy Name: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Phone Number: (_____) _____ - _____

AUTHORIZATION and HIPPA PRIVACY NOTICE

Please Read:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my copay and/or any coinsurance monies are due at the time of service. Should my insurance carrier require a referral and I fail to provide one, I agree to pay for all charges associated with the care provided by Loudoun Ophthalmology Associates, LLC. I agree to reimburse the fee of any collection agency, which may be based on a maximum of 43% of debt, and all costs, and expenses, including reasonable attorneys' fees, we occur in such collection action. I hereby authorize assignment and payment directly to Loudoun Ophthalmology Associates, LLC any major medical benefits due me for services provided by them.

X _____ _____
Signature of Responsible Party Date

HIPAA STATEMENT

I have read and agree with Loudoun Ophthalmology Associates, LLC. ***HIPAA Notice of Privacy Policy.*** I hereby authorize Loudoun Ophthalmology Associates, LLC to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the physician(s) of Loudoun Ophthalmology Associates, LLC to consult as needed in their sole discretion with other medical providers regarding my medical care. HIPAA form will be provided upon request.

X _____ _____
Signature of Responsible Party Date

MEDICAL HISTORY FORM

Patient Name: _____

MEDICAL HISTORY: ***DO YOU HAVE?***

DIABETES: …….. **yes** ☐ no ☐
If yes, for how many years? _____
Highest blood sugar within the past month? _____
Any breathing problem: ……..... **yes** ☐ no ☐
High blood pressure: ……... **yes** ☐ no ☐
HIV: ……... **yes** ☐ no ☐
History of cancer: ……... **yes** ☐ no ☐ → If yes, type/date_____
Previous stroke: …….. **yes** ☐ no ☐
LIST any other medical problem(*s*)→1)_____ 2)_____ 3)_____4)_____ ☐ **NONE**

CURRENT EYE PROBLEM:

Do you have any **eye pain**? …… **yes** ☐ no ☐ → When did it start? _____ → Which eye? _____
Are you having **blurry vision**? ……...**yes** ☐ no ☐ → When did it start? _____ → Which eye? _____
Do you experience seeing black spots, shadows, or shapes (i.e. **floaters**)?.. **yes** ☐ no ☐ → Which eye? _____
Do you experience seeing **flashes of light**? …… …..**yes** ☐ no ☐ → Which eye? _____

PAST EYE HISTORY

Do you have any **eye disease?**…… **yes** ☐ no ☐
If yes, please explain:_____
When was your **last eye exam**? _____ ago
Do you use **contact lenses:** ……..... **yes** ☐ no ☐
Do you wear **glasses**? …… **yes** ☐ no ☐ → ☐ check here if glasses are **only** for reading
Do you have a **lazy eye**? …… **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
Ever been **hit in your eye**?.. **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
Have you had eye **surgery** before?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates below:
_____
Have you had **laser** eye surgery?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates:_____

EYE DROPS: (list all eye drops you use currently and how often you use them**).** ☐ **NONE**

_____ _____
_____ _____

MEDICATIONS (PILLS): (only write down the name, NOT the dose)**……...** ☐ **NONE**

_____ _____ _____
_____ _____ _____

ALLERGIES: Are you **allergic** to any medicine:…… **yes** ☐ no ☐
If yes, please provide name(s) of the medicine(s)→→

FAMILY AND SOCIAL HISTORY:

Anyone in your family have **glaucoma**?..... **yes** ☐ no ☐ If yes, who: _____
Is anyone in your family **cross-eyed**?..... **yes** ☐ no ☐
Any **eye disease** that runs in your family?.....**yes** ☐ no ☐ If yes, please explain:_____
Do you smoke?..... **yes** ☐ no ☐ →→ Do you drink?.....**yes** ☐ no ☐

GENERAL MEDICAL QUESTIONS: (Do you have the following?)

Fever:……**yes** ☐ no ☐
Frequent Headaches: …… **yes** ☐ no ☐
Are you pregnant: ……**yes** ☐ no ☐
Muscle weakness: ……**yes** ☐ no ☐
Numbness: ……**yes** ☐ no ☐
Rash: ……**yes** ☐ no ☐
Cough: ……..**yes** ☐ no ☐
Have you had a heart attack: …… **yes** ☐ no ☐
History of Tuberculosis: ……...**yes** ☐ no ☐
Hepatitis C…… **yes** ☐ no ☐

Diarrhea: …… **yes** ☐ no ☐
Blood in your stool: ……..…… **yes** ☐ no ☐
Recent weight loss: …… **yes** ☐ no ☐
Recent decreased appetite: ……..…… **yes** ☐ no ☐
Pain when you urinate: ……...… **yes** ☐ no ☐
Joint pain: …….. **yes** ☐ no ☐
Muscle pain: …….. **yes** ☐ no ☐
Low back pain: …….. **yes** ☐ no ☐

_____ _____
SIGN HERE DATE

APPOINTMENT CANCELLATION POLICY

Dear Valued Patient,

Loudoun Ophthalmology Associates has instituted a "No Show" Policy.
Giving our undivided attention to each and every patient is important to us, as we're sure it is to you. We block out the time for your visit. In fairness to all patients and as a courtesy to our staff, please call our office at least 24 hours prior to your appointment if you need to cancel or reschedule.

A $40 missed appointment fee will be charged for any appointment not cancelled at least 24 hours in advance.
Insurance plans are not responsible for No Show Fees. It is the responsibility of the patient to pay this bill upon receipt.

• IF A PATIENT IS MORE THAN ***20*** MINUTES LATE FOR AN APPOINTMENT, THE APPOINTMENT WILL BE CONSIDERED MISSED AND WILL NEED TO BE RESCHEDULED.

• IF A PATIENT IS A NO SHOW 3 TIMES, THEY WILL BE DISENROLLED FROM THE PRACTICE.

THIS POLICY MUST BE SIGNED IN ORDER TO BE A PATIENT OF **Loudoun Ophthalmology Associates**.

Signature: _____

Patient Name: _____

Date: _____

Card Billing Authorization

By signing this policy I authorize Loudoun Ophthalmology associates LLC to save my card information in a secure and encrypted server. I authorize Loudoun Ophthalmology Associates LLC to bill my card for any balances incurred during my visit. I understand that Loudoun Ophthalmology will bill my insurance carrier first and the remaining balance will be my responsibility.

After my insurance is billed Loudoun Ophthalmology Associates LLC will charge my card for the amount designated on my Explanation of Benefits (EOB) which is provided by my insurance.

The card I am designating for this purpose will be charged on the first of the month.

A receipt for each payment will be provided to me via email only and the charge will appear on my bank statement as "Loudoun Ophthalmology"

***Please note, this authorization also applies to any non-covered charges by your insurance and understand you are ultimately responsible for your balance.**

My bill will be sent by email on the first of the month, I will have until the first of the following month to pay. If a payment has not been provided BEOFRE the first of the month, my card will be charged on this date.

Example: Bill sent 01/01. Payment is due 01/31. Card is charged 02/01.

Email: _____

I _____ (Patient's Name) authorize **Loudoun Ophthalmology Associates LLC** to charge my credit/debit card for my balance.

I agree to notify Loudoun Ophthalmology Associates LLC in writing of any changed in my account information at least 15 business days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the bills and payments may be executed on the next business day. For ACH debits to my checking/savings or credit card amount, I understand that because these are electronic transactions these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of a transaction being rejected for non-sufficient funds (NSF), I understand that Loudoun Ophthalmology Associates LLC may at its discretion attempt to process the charge again within 10 days. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. Law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank so long as the transactions correspond to the terms indicated within this form.

Signature: _____ Date: _____