DOMINION EYE CARE

Patient Demographic Information

First Name:_____ **MI:** _____ **Last Name:**_____

Date of Birth: _____ **Social Security Number:**_____

Mailing Address: _____ **City:**_____

State: _____ **Zip Code:** _____ **Home Phone Number:**(____)_____

Cell Phone Number:(_____)_____ **Work Phone Number:**(____)_____

Email Address:_____

How would you like to receive appointment reminders? (check all that apply) □ Text □ Email □ Voice Mail

Preferred Contact Method for Test Results: □ Home Phone □ Cell Phone □ Mail □ Patient Portal

Race: □ Black/African American □ White/Caucasian □ Asian □ Other □ Declined to Answer

Ethnicity: □ Hispanic/Latin □ Not Hispanic/Latin □ Declined to Answer

Preferred Language: □ English □ Spanish □ Other: _____

Birth Sex: □ Male □ Female **Marital Status**: □ Single □ Married □ Divorced □ Widowed □ Partner

How did you hear about us? □ Physician Referral (Name of physician) _____

□ Friend/Family Member □ Internet Search □ Insurance Company

Insurance Company: _____ Member ID: _____
Policy Holder's Name: _____ Date of Birth: _____
Relationship to Patient: _____ Social Security Number: _____

Secondary Insurance Company: _____ Member ID: _____
Policy Holder's Name: _____ Date of Birth: _____
Relationship to Patient: _____ Social Security Number: _____

Emergency Contact Name: _____ Relationship:_____
Phone Number: (_____)_____

DOMINION EYE CARE

Patient Financial Responsibility Policy

Welcome to Dominion Eye Care, P.C. We are pleased you have chosen our practice for your eye care. We are committed to providing you with the highest quality service available. We ask that you carefully read and sign the following policy:

We must emphasize, our relationship IS WITH YOU and NOT YOUR INSURANCE CARRIER. As a courtesy, we will file your claim with your PRIMARY insurance company IF we are participating providers. However, YOU ARE THE SOLE RESPONSIBLE PARTY for all charges incurred and guarantee payment thereof. Worker's Compensation claims will be filed IF ALL INFORMATION IS PROVIDED AT THE TIME OF SERVICE. Payment must be received within 45 days, or it becomes the patient's responsibility. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/ responsible party. YOU are expected to understand your benefits coverage and responsibility, this includes obtaining any referrals / authorizations which your insurance company requires BEFORE care is provided. YOU are responsible for 100% of the co-pays AT THE TIME SERVICES ARE RENDERED as well as co-insurance payments and contractual obligation(s) assigned by your insurance company. Should a monthly payment plan become necessary, arrangements can be made through our office. Failure to pay for services or adhere to a payment plan will result in collection action. All collection costs incurred by Dominion Eye Care, P.C., including attorney's fees, will become the sole responsibility of the financial responsible party named herein. In consideration of the services performed by Dominion Eye Care, P.C. you agree to abide by the terms of this Financial Statement. In accordance with The Payment Card Industry Data Security Standard (PCI-DSS), and with your expressed written consent, Dominion Eye Care, P.C. offers you the option to store credit card information on-file. We will not store the information unless you ask us to, and you may opt-out at any time. Returned checks will be assessed a $55 fee.

Missed Appointment and Cancellation Policy

There will be a $65 No-Show fee if you do not show up for your appointment. There will be a $65 cancellation fee for appointments canceled less than 24 hours of the appointment. There may be additional fees associated with filling out forms as requested by the patient not presented at the time of service.

PATIENT'S AUTHORIZATION

I hereby authorize Dominion Eye Care, P.C. to apply for benefits on my behalf for services rendered. I request payment from my insurance company be made directly to Dominion Eye Care, P.C. I authorize the release of any necessary information, including medical information for this or any related claim to my insurance company, or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in the place of the original. I may revoke this authorization at any time in writing.

_____ _____

Patient / Agent / Guardian Signature Date

DOMINION EYE CARE

Patient Consent & Authorization for Release of Protected Health Information

This authorization pertains to the medical information about my EYES/OPHTHALMOLOGY.

I hereby give my permission to Dominion Eye Care, P.C. to release, use or disclose my personal health information to (Person(s) permitted to receive this information, i.e., Family member, Friend, Guardian, etc.):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- I understand that I may revoke this authorization at any time by providing written notification to: Dominion Eye Care, P.C. The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in the reliance upon this authorization prior to the effective date of revocation.
- I also understand that I do not have to sign this authorization to receive treatment, payment, or to enroll or be eligible for benefits.
- I understand that unless I request in writing, this authorization will expire 3 (three) years from the below signed date.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the named recipient and may no longer be protected by HIPPA's privacy rules after the authorized disclosure.

_____ _____

Patient / Agent / Guardian Signature Date

MRN

DOMINION EYE CARE

MEDICAL HISTORY FORM

Patient Name: _____ Patient Date of Birth: _____

Past Medical History

- ☐ Anxiety Disorder
- ☐ Arthritis (Type: _____)
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer (Type: _____)
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Depressive Disorder
- ☐ Diabetes (Type: _____)
  - Last A1C: _____
  - Last Blood Sugar: _____
- ☐ Gastroesophageal Reflux Disease
- ☐ Heart Disease
- ☐ High BloodPressure
- ☐ Hearing Loss
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stroke
- ☐ Other:

Past Surgeries

- ☐ Abdominal Surgery
- ☐ Coronary Artery Bypass Graft
- ☐ Colostomy
- ☐ Colon
- ☐ Heart
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Replacement
- ☐ Kidney
- ☐ Liver
- ☐ Tonsillectomy
- ☐ Other:

Ocular History

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract of Right Eye
- ☐ Cataract of Left Eye
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy
- ☐ Difficulty w/ Reading ☐ Yes ☐ No
- ☐ Drive at Night ☐ Yes ☐ No
- ☐ Dry Eyes
- ☐ Elevated Eye Pressure
- ☐ Epiretinal Membrane ☐ Right ☐ Left
- ☐ Floaters ☐ Right ☐ Left
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration ☐ Right ☐ Left
- ☐ Ophthalmic Migraine
- ☐ PVD ☐ Right ☐ Left
- ☐ Retinal Tear ☐ Right ☐ Left
- ☐ Retinal Detach ☐ Right ☐ Left
- ☐ Strabismus ☐ Right ☐ Left
- ☐ Other:

Ocular Surgeries

- ☐ Bleb ☐ Right ☐ Left
- ☐ Corneal Transplant
- ☐ Cataract ☐ Right ☐ Left
- ☐ Eyelid
- ☐ Injections ☐ Right ☐ Left
- ☐ LASIK
- ☐ Laser Iridotomy ☐ Right ☐ Left
- ☐ Laser Trabeculoplasty ☐ Right ☐ Left
- ☐ PRK
- ☐ Punctal Plugs ☐ Right ☐ Left
- ☐ Retinal ☐ Right ☐ Left
- ☐ Strabismus ☐ Right ☐ Left
- ☐ Tube Shunt ☐ Right ☐ Left
- ☐ Trabeculectomy ☐ Right ☐ Left
- ☐ Trabeculotomy ☐ Right ☐ Left
- ☐ Other:

Medication Name, Milligram, Frequency
(or provide current list from PCP)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies to Medications (name & reaction):

Allergy to Latex: ☐ Yes ☐ No

Family Eye History

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other:

Pharmacy Name and Location

Primary Care Physician:

Vaccines

- ☐ Flu
- ☐ Shingles
- ☐ COVID-19 ☐ COVID Booster

What eye concern is bringing you in for your visit today?

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

DOMINION EYE CARE

Your Information. Your Rights. Our Responsibility

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

- **You have the right to:** Get a copy of your paper or electronic medical record; Correct your paper or electronic medical record; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; File a complaint if you believe your privacy rights have been violated.
- **We May Use and Share Your Information as We:** Treat you; Run our organization; Bill for your services; Help with public health and safety issues; Comply with the law; Respond to organ and tissue donation requests; Work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions.
- **When It Comes to Your Health Information, You Have Certain Rights:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or summary of your health information, usually within 30 days of your request, and we may charge a reasonable, cost-based fee.
- **You Can Ask Us to Correct Your Medical Record:** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **You Can Request Confidential Communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **You Can Ask Us to Limit What We Use or Share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **You Can Get a List of Whom We Have Share Information With:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **You Can Get A Copy of This Privacy Notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **You Can Choose Someone to Act for You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **You Can File A Complaint if You Feel Your Rights Are Violated:** You can complain if you feel we have violated your rights by contacting us using the information on the last page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
- 200 Independence Ave SW, Washington, DC 20201, or by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
- **For Certain Health Information, You Can Tell Us Your Choices About What We Share:** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- **In These Cases, We Never Share Your Information Unless You Give Us Written Permission:** Marketing purposes, sale of your information, and sharing of most psychotherapy notes
- **In the Case of Fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you again.
- **We Typically Use or Share Your Health Information in the Following Ways:** To treat you- we can use your health information and share it with other professionals who are treating you (example: A doctor treating you for an injury asks another doctor about your overall health condition). To run our organization- We can use and share your health information to run our practice, improve your care, and contact you when necessary (example: We use health information about you to manage your treatment and services), including email and text messages asking you to review and give your opinion on our services.
- **How Else Can We Use or Share Your Information?** We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see:www.hhs.gov/ocr/privacy/hipss/understanding/consumers/index.html We can share health information about you to help with public health and safety issues such as:
  - Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety
  - We can share your information for health research; To comply with state or federal laws that require it, including the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law; With organ procurement organizations; With a coroner, medical examiner, or funeral director when an individual dies; To address workers' compensation requests regarding claims; For law enforcement purposes with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services; In response to a court or administrative order, or in response to a subpoena.
- **We Are Required By Law To Maintain the Privacy and Security of Your Protected Health Information (PHI):** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information; We must follow the duties and privacy practices described in this notice and give you a copy of it; We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by letting us know in writing. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
- **Changes to the Terms of This Notice:** We can change the terms of this notice and it will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.
- **Other Instructions for This Notice:**
  - Effective March 4, 2019
  - Privacy Official: Elicia T. Wright, 703-361-3128 ext. 501
  - We never market or sell personal information

_____ _____ _____

Patient/Legal Guardian Signature