Eye Physicians
& SURGEONS

Dr. Clubb New Patient Paperwork

Please fill out all forms and either do one of the following:

1. Email forms to records@eyephys.com
2. Fax to 703-698-8884
3. Or bring to your appointment

Please arrive 15 mins early with insurance and photo ID

Please note that any new patient that is 15 minutes past there scheduled appointment time will need to be rescheduled

Feel free to call our office if you have any questions

Office Number: 703-698-8880

Eye Physicians & SURGEONS

Medical Eye Exams VS Routine Vision Exam

Vision Exam (Routine Exam):

A routine vision exam or "wellness exam" takes place when you have an eye examination **without a medical problem.** Glasses and contact lens prescriptions may be updated using your vision insurance. (*For example: if you need new glasses/contact lenses or if you just want your yearly exam.)*

Medical Eye Examination (Comprehensive Exam):

A visit will be billed as a medical eye examination whenever a patient is being **evaluated, followed, or treated for a medical condition or symptom. Imaging and testing for diagnostic purposes can only be done under medical insurance.**(*For example: Diabetic eye exams, complaints of dry eye, glaucoma, macular degeneration, cataracts, eye irritation/itching.)*

PLEASE SELECET ONE OF THE FOLLOWING

For patients with VSP (Vision Service Plan): A medical **and** vision exam can be performed on the same day. Glasses prescriptions and/or contact lens services will be billed under VSP. If any medical treatment is identified, **part of your exam will be billed through your medical insurance**, **making you subject for payment of co-pays/co-insurance and deductibles. Medical insurance will be billed first followed by VSP.**

_____ I have VSP and I want ONLY my VSP billed.

_____ I have VSP and I want my MEDICAL AND VSP billed.

For patients with Eyemed: A medical and vision exam **CANNOT** be performed on the same day per insurance regulations. If you report symptoms during your visit related to an eye problem, disease, or injury, or if the doctor determines that your eye health exam falls under the category of a medical eye examination, your visit will be billed to your medical insurance, making you subject for payment of co-pays/co-insurance and deductibles.

_____ I have Eyemed and I want ONLY my Eyemed billed

_____ I have Eyemed and I want ONLY my MEDICAL INSURANCE billed

(Also known as Blue View Vision)

OPTIONAL VISUAL FIELD SCREENING

(Does not apply if using medical insurance)

To provide total vision care to our patients, we are now offering our automated visual field screening in combination with your annual vision examination. This is a state of the are test preformed to rule out early signs of ocular disease. This test involves the use of a special computer to evaluate both your central and peripheral vision. We recommend that all our patients over the age of 21 receive the screening. **There is an additional charge of $40.00 for this screening.**

_____Yes, I do want the visual field screening **_____No, decline the visual field screening**

Pupillary Dilation through Vision Insurance (Optional)

Dilation involves the use of eye drops to dilate the pupils and the patient is instructed to wait approximately twenty to thirty minutes for adequate dilation to occur. Distance vision may be blurred and near vision will be blurred for about 4-6 hours as the dilation gradually wears off. There will also be some light sensitivity for which the front desk will supply you with a pair of complimentary disposable sunglasses. Some patients feel uncomfortable with driving after being dilated, and wish to return to our office with a designated driver at a later visit.

_____ Yes, I want my eyes dilated at this time **_____ No, I do not want my eyes dilated at this time**

_____	_____	_____
Printed Patient Name	**Signature – Patient/Guardian**	**Date**

Eye Physicians & Surgeons, Inc.

Patient Financial Policy

All out-of-pocket balances (copayments, co-insurances, and deductibles) are due at the time of service unless previous arrangements have been made in writing with the office. It is the Patient's/Responsible Party's duty to know what their out-of-pocket expenses will be before seeking treatment.

Payment Options:

- You may pay your out-of-pocket costs at the time of service by Check, Cash, or Credit Card.
- There is a fee of fifty-five dollars ($55) for any check returned by your bank for any reason.
- Failure to pay your out-of-pocket balance at the time of service will result in an **administrative service charge of ten dollars ($10)**. This administrative charge is not the responsibility of your insurance carrier, due to the fact that you did not abide by their contractual terms, and this charge will not be billed to the carrier for a denial.

Past Due Accounts:

- If at any time you have a balance due which is more than ninety (90) days old your account will be referred to an outside collection agency without notice.
- Any balance that is more than ninety (90) days old will be billed finance charges at the rate of 1.5% per month (18% per annum).
- If we have to refer your account to a collection agency or an attorney for collections, you hereby agree to pay for all collection costs incurred, including 35% attorney's fees.
- Furthermore, you understand that if your account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.
- We will also contact your insurance carrier informing them of your failure to uphold your agreement with them, which at their discretion, may result in termination of your policy.

Missed Appointments:

- The second time a patient does not arrive on time for an appointment, or cancels with less than 24 hour notice, a missed appointment fee of twenty-five dollars ($25) **will** be charged.
- If a patient misses a Saturday appointment, or cancels with less than 48 hour notice, a missed appointment fee of twenty-five dollars ($25) **will** be charged.
- Missing a surgical appointment without notification seven business days prior to the surgery will result in a missed fee of $300.
- All missed fees must be paid **before** a new appointment is scheduled.
- Patients with three or more missed appointments without advance notification will be terminated from the practice.

Professional Courtesy:

- By law, this practice cannot and will not reduce a charge out of professional courtesy.

Pre-Authorization:

- Many insurance companies, such as HMOs, require pre-authorization and/or referrals prior to obtaining specialty care. It is **your responsibility** to contact your insurer and/or primary care physician (PCP) to determine the need for and obtain a pre-authorization and/or referral.
- Failure to obtain a pre-authorization and/or referral may result in lower reimbursement or claim denial from the insurance company, **in which case you will be responsible for the charges**.

Forms & Medical Records:

- From time to time, various forms, such as disability or DMV forms, need to be completed. There is a twenty to thirty-five dollar ($20-$35) clinical administrative fee to complete each form.
- There is a thirty-five dollar ($35) administrative fee associated with the copying and/or release of medical records. Please inquire at the front desk by requesting a Record Release Form.

By signing this agreement, you attest to having read and understood this policy, and agree to comply with all of the terms and conditions contained herein.

Patient's Name: _____
Responsible Party (if patient is a dependent): _____
Signature: _____ **Date:** _____

Eye Physicians & Surgeons, Inc.

Meaningful Use Information

Due to changing healthcare laws, we are required to collect more patient demographic information.

FIRST NAME: _____ **LAST NAME**: _____

PREFERRED LANGUAGE: _____

RACE: (Circle One)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Island

White

Other

Decline to Answer

SMOKING STATUS: (Circle One)

Never Smoker

Current every day smoker. What year did you start? _____

Current some day smoker. What year did you start? _____

Former smoker. What year did you start?_____ Quit? _____

Unknown if ever smoked

Decline to answer

Preferred Pharmacy: _____ **Pharmacy Phone/Fax**: _____

Pharmacy Address: _____

I agree that Eye Physicians and Surgeons may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

PATIENT PORTAL REGISTRATION

Registration to the portal provides you with online access to the office anytime and anywhere. You will be able to request appointments & refill prescriptions, access your medical records, securely message the staff and doctors, set up appointment reminders, and much more.

TO ACCESS THE PORTAL, please provide us with your email address.

EMAIL: _____

An email will be sent to you with directions on how to register for the portal. **The email you provided will be your user name.** When prompted enter the pin provided via email for your first log in.

TO OPT OUT OF THE PORTAL, please check the following box.
Keep in mind that if you require records you will have to pay a fee as outlined in our financial policy. ☐

Patient Signature: _____ **Date**: _____

Eye Physicians & Surgeons, Inc.

Patient Demographic Information

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

Street Address: _____

City: _____**State**: _____**Zip**: _____

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

Social Security Number: _____-____-_____ (last 4 is sometimes needed to pull insurance information)

Sex: (circle): Male Female

Marital Status (circle): Single Married Divorced Widowed

Date of Birth: _____/_____/_____

Email Address:_____

Employment Status (circle): Full-time Part-time Retired Student (Full or Part)

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information

If the patient is the person responsible for paying any out of pocket expense, please mark "self" and sign the Assignment and Release statement.

Patient's relationship to the responsible party (circle): Self Spouse Child

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

Street Address: _____

City: _____**State**: _____**Zip**: _____

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

Social Security Number: _____-____-_____ (last 4 is sometimes needed to pull insurance information)

Sex: (circle): Male Female

Date of Birth: _____/_____/_____

Employment Status (circle): Full-time Part-time Retired Student (Full or Part)

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Eye Physicians & Surgeons, Inc.

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment directly to Eye Physicians & Surgeons, Inc. of any medical/testing benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s), collect any balance due or deemed necessary pursuant to State or Federal law, statute or regulation.

NON-COVERED SERVICES

I accept responsibility for paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Eye Physicians & Surgeons, Inc. and the insurance carrier. Furthermore, I acknowledge that it is my responsibility to obtain any necessary healthcare care service plan authorizations/referrals before my visit takes place. Moreover, I agree that it is my responsibility to contact my insurance carrier to confirm that the doctor I am seeing is in my insurance network and/or plan, before my visit takes place. If I fail to do so, I accept that this visit will be a non-covered service, and I will be responsible for any and all charges related to my visit.

PRACTICE FINANCIAL POLICIES

I have read and agree to the full Patient Financial Policy of Eye Physicians and Surgeons, Inc., part of which is summarized here. I recognize that payment for all co-pays, deductibles, co- insurances and other pre-determined out-of-pocket expenses are expected at time of service.

I acknowledge that it is my responsibility to know the amount of my out-of-pocket expenses and I agree to check with my insurance carrier before each visit to confirm any changes. I recognize that failure to pay these out-of-pocket expenses at time of service will lead to a **ten dollar ($10) administrative service charge**. I recognize that Eye Physicians & Surgeons, Inc. reserves the right to charge me for missed appointments and will bill my account for finance charges at the rate of 1.5% per month (18% per annum) on my balance(s) after a period of ninety (90) days from the date of service. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof, including 35% attorney's fees. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

_____ _____/_____/_____

Patient/Responsible Party Signature Date of Signature

Medical History Questionnaire

Dear Patient: All major health insurers and Medicare now require us to obtain in depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation.

Today's Date: _____/ _____/ _____

Name: _____ Birth Date: _____/ _____/ _____

Reason for visit: _____

Primary Care Physician: _____ Date of last physical: _____
Are you allergic to any medications or latex? ☐Yes ☐No If so, which: _____

Please list the names and dosages of any prescription or over-the-counter medications you are currently taking:

_____

_____

List all major illnesses (glaucoma, diabetes, high cholesterol, etc.) or injuries (concussion, etc): _____

_____

List any surgeries you have had (cataract, appendectomy, etc.): _____

Ocular History

Have you ever worn glasses? ☐Yes ☐No When was your last eye exam? _____

Do you currently wear contact lenses? ☐Yes ☐No If yes, what brand and powers? _____

_____

Have you ever had LASIK or refractive surgery? ☐Yes ☐No If yes, date of surgery: _____
Are you interested in getting LASIK? ☐Yes ☐No

Have you ever had eye surgery? ☐Yes ☐No If yes, please describe: _____

Check any of the following that you have had: ☐Crossed Eyes ☐Lazy Eye ☐Drooping Eyelid ☐Double Vision ☐Prominent Eyes ☐Glaucoma ☐Retinal Disease ☐Cataracts ☐Eye Injury ☐Eye Infection ☐Dry Eyes ☐Itchy Eyes ☐Floating Spots in Vision ☐Sensitivity to Light / Glare

Hours a day you work on a computer? _____ Would you like to hear about computer glasses? ☐Yes ☐No

Social History

Do you drive? ☐Yes ☐No If yes, do you have visual difficulty when driving? ☐Yes ☐No
Do you smoke? ☐Yes ☐No If YES, how much? _____ How many years? _____
Do you drink alcohol? ☐Yes ☐No If YES, how much? _____

Review of Systems

Do you ***currently have*** any problems in the following areas ? If YES, please provide details.

	YES	NO	Details (condition, date of diagnosis, and treatment)
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, asthma, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, high cholesterol, anemia, sickle cell, blood transfusions, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
CANCER (please list type)			
OTHER			

Family History

Please note any family history (parents, grandparents, siblings: living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataract	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Crossed Eyes	☐	☐	_____
Blindness	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____

Other: _____

Doctor's Signature: _____ Date: _____

Eye Physicians and Surgeons, Inc.
Diseases and Surgery of the Eye • Cornea and External Disease • Refractive Surgery
3031 Javier Road • Suite 300 • Fairfax, Virginia 22031 • Phone: 703-698-8880 • Fax: 703-698-8884
5249 Duke Street • Alexandria, Virginia 22304 • Phone: 703-823-5205 • Fax: 703-823-9391

Acknowledgement Form
Notice of Privacy Practice

By signing this form, you acknowledge that you have read the Notice of Privacy Practices for Eye Physicians and Surgeons, Inc., which describes Eye Physicians and Surgeons' use and disclosure of your individually identifiable health information and your rights with respect to this information.

If you refuse to sign this form but receive health care from Eye Physicians and Surgeons, Inc., you have implicitly consented to Eye Physicians and Surgeons' use and disclosure of your individually identifiable health information as described in our Notice of Privacy Practices.

Patient Signature: _____

Patient Name (Printed): _____

Date: _____ / _____/ _____

If a patient is unable/unwilling to acknowledge receipt or is a minor, complete the following:

Patient is: _____ A Minor
_____ Unable
_____ Unwilling

Signature of Personal Representative (if applicable):
_____

Relationship to Patient: _____

Personal Representative's Name: _____

Eye Physicians & Surgeons, Inc.

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

WHAT IS A REFRACTION?

A refraction is the procedure that determines a patient's eyeglass prescription. Receiving a glasses prescription is **not covered** by most major medical insurance policies. Vision insurance policies, however, **do cover** the refraction.

If the doctor determines that you need to have the refraction done and your insurance does not pay for it, you will be held responsible for paying the eighty-five dollar fee ($85) at the time of service, along with any other fees you are normally responsible for, such as co-payments and/or deductibles.

If you are a Medicaid recipient, please read the following:

- **Refractions will be performed for diagnostic purposes only as part of a medical exam when deemed necessary by the provider.**
- **Refractions will not be performed for the sole reason of "obtaining a new prescription or to check if my vision has changed." These services will need to be obtained elsewhere by a provider participating with the routine vision coverage of your plan.**
- **Written prescriptions will not be given for the purpose of obtaining new glasses/contacts**

Please check one of the following options and sign below:

_____ **YES,** I would like the doctor to check whether I need a new glasses prescription.
By agreeing, I understand that the refraction may not be a covered service under my medical insurance plan and that I will pay the eighty-five dollar fee ($85) at the time of service if a glasses prescription is provided. Eye Physicians and Surgeons, Inc. will submit the refraction to your insurance and if they cover the service, a refund will be issued.

_____ **NO,** I would not like a refraction today.

_____ **MEDICAID RECIPIENT,** I understand that a refraction will only be performed for diagnostic purposes and I will not receive a written prescription to use in obtaining glasses or contact lenses and that I will need to obtain this service with another provider.

_____
PATIENT NAME

_____
PATIENT SIGNATURE

_____
DATE OF SIGNATURE

Eye Physicians & Surgeons, Inc.

Visual Functioning Index (VF-8R) Patient Questionnaire

Name:_____ Date of Birth:_____

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
2. Reading a newspaper or book?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
3. Seeing steps, stairs or curbs?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
6. Writing checks or filling out forms?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity
8. Watching television?	□ Yes □ No □ Not Applicable
If yes, how much difficulty do you currently have?	□ A little □ A moderate amount □ A great deal □ Unable to do the activity