Prince William Eye Associates

Date ____/____/______

Patient Name: Last: ______________________ First: ______________________
Address: ______________________ **Phone:** (_____) ______________
City, State, Zip: ______________, ______ ________ **Cell:** (_____) ______________
E-Mail: ______________________ **Text Messaging:** Yes No
Birthdate: _____/_____/_______ **Gender:** M F **Social Security #** _____-_____-_______
Ethnicity/Race: ______________________ **Language Preference:** ______________
Employer: ______________ **Occupation:** ______________ **Hobbies:** ______________

General Health History (Please list **any** and **all** known problems): (circle) *Check here if None:* ☐

Seasonal Allergies Hypertension Heart Disease High Cholesterol Thyroid Disease
Depression Urinary Disorder Autoimmune Disorder Skin Disorder Blood Disorder
Arthritis Kidney Cancer Asthma Height: _______ Weight:_____
Diabetes (Please include date of diagnosis): ____________ A1C:______
Other health issues (please specify): ______________________________
Smoking Status: Never smoked Occasional Everyday *If Smoker, Years Smoked:* _______

Medication History (Please list ***any*** and ***all*** medications currently taken): *Check here if None:* ☐

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Allergies to Medications: ______________________________ *Check here if None:* ☐

Personal Eye History (Please list ***any*** and ***all*** known eye problems) *Check here if None:* ☐

Glaucoma Cataracts Keratoconus Macular Degeneration
Eye Injury Lazy Eye Eye Surgery ______________ Retinal Detachment
Allergies Dry Eye Diabetic Retinopathy
Other (Please specify): ______________________________
Do you wear glasses?: Yes No For: Distance Near Computer
Do you wear contact lenses?: Yes No Type/Brand: ______________________
Are you interested in LASIK?: Yes No Done in past (Please list year): ______________

Family Health History (Please list ***any*** and ***all*** known problems) *Check here if None:* ☐

Hypertension Relationship: ______________ Glaucoma Relationship: ______________
Diabetes Relationship: ______________ Cataracts Relationship: ______________
Thyroid Disease Relationship: ______________ Macular Degeneration Relationship: ______________
Cancer Relationship: ______________ Keratoconus Relationship: ______________
Other (Please list any other known conditions not listed above): ______________________

Emergency Contact: ______________ Relationship:____________ Phone: (_____) __________
Primary Care Physician: ______________________________ Phone:(_____) __________
Vision Insurance: ______________________ **Health Insurance:** ______________________

Please state the main reason for your visit today: ______________________________

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All information disclosed on this form is strictly confidential and conforms to HIPAA regulations.

_____ Recieved a copy of the Privacy Practices
_____ Declined a copy of the Privacy Practices Print Name________________ Signature________________ Date________

PATIENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

1.**FINANCIAL RESPONSIBILITY**: I agree to pay Prince William Eye Associates and its assigns, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment. However, Prince William Eye Associates will bill any applicable insurance as a courtesy. I assign Prince William Eye Associates all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to Prince William Eye Associates for all charges and services not covered by this assignment and promise to pay any remaining balance.
2. **COLLECTION POLICY**: An account is considered delinquent when insurance has not paid within 30-45 days after Prince William Eye Associates billing or if payment in full has not be received within 30 days of the final insurance payment. Delinquent accounts can be assessed penalties and interest and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceeding.
3. **CONTINUING SERVICES**: I understand that Prince William Eye Associates may create a separate account for each time which services or expenses are incurred on this account. I understand that all professional services are not refundable but can receive refunds on the merchandise. I acknowledge and agree that the terms and conditions in this Financial Responsibility and Assignment of Benefits as outlined above shall be effective for continuing and additional services incurred after execution of this form.

ABOUT YOUR INSURANCE

There are two types of health insurance that may help pay for your eye care services and materials. You may have both and our practice accepts both: 1) Medical Insurance (such as Blue Cross/Blue Shield and Medicare) and, 2) Vision Insurance (such as VSP and EyeMed).

- Vision insurance only covers **ROUTINE VISION EXAMS** along with eyeglasses and contact lenses.
- Medical insurance **must be used** if you have any eye health problem that has ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history.
- Most medical insurance plans do have routine vision screening benefits but these are very different than an actual vision examination. Vision screenings are basic screenings for eye disease. **They do not cover diagnosis, management or treatment of eye diseases nor do they allow for a prescription to be written for eyeglasses or contact lenses.**
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in an attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

I have read and understand the above policies.

PATIENT NAME: ______________________________ ______________________________

Patient or Legal Guardian Signature Date