

Physicians & Surgeons PC

103 W. South Street

158 Front Royal Pike Suite 300

Woodstock, VA 22664

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 before rescheduling a new appointment. This pertains to appointments scheduled Monday through Friday.
(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.
New Patient em	ergencies: 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.
Regardless of in	s/charges quoted above are subject to change at any time, and without prior notification. surance coverage (in network or out of network) patients will still be accountable for any bills we Care Physicians and Surgeons.
	Patient Signature Date

atients First Name	_ Middle Init	tiall	Last Name			
Iow would you like our staff to address you?			_			
Date of Birth/Age Sex	x					
Mailing Address		City_			_State	Zip
f different, full street address			City		_State	Zip
Iome Phone ()Cell Ph	none ()				
Best Time to CallEmail Address	ess					
SN/Marital Statu	us					
referred Pharmacy		City/Stat	te			
Iow did you hear about us?						
f Referred by PCP/Medical Doctor please provide na	ame of PCP	/Medical Do	octor			
	Phone ()				
Employer	_ 1 110110 (/				
cmployer full Time, Part Time Occupation or school name						
	Relationship	to Patient		Ph		
Complete this section below only if a secondary insured or other responsible Party's Name	Relationship spouse, ble party	parent,	guardi accour	Pho an is p nt:	rimar	y insure
Complete this section below only if a secondary insured or other responsible Party's Name fidifferent address from patient, please provide information.	Relationship spouse, ble party I tion below.	parent, y for the	guardi e accour	Pho an is p nt: /	rimar _ ^{Age}	y insure
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Relationship of patient to the policyholder: SELF SPOUSE PARTNER CHILD OTHER (please circle answer)

Patient Registration Information

Date: _____

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

Patient's Signature:

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.

Date:

-		
	HMO OR PPO PATIENTS	
If any services are performed in our office co-pays that are generated from their out	and prior authorizations have been obtained, I am responsible for any deduction for network benefits.	ons oi
Patient's Signature:	Date :	
	General Informed Consent	
outpatient treatment from professionals at therapy services, diagnostic tests, medicate judgment. I understand that all services ar creed, national origin, religion, or handicate event of an emergency, I authorize Eye Catreatment as may be deemed advisable unbilling, treatment and healthcare operation of my insurance carriers the review the re-	& Surgeons, PC to carry out all procedures ordered by my physician. I request Eye Care Physicians & Surgeons, PC and consent to all: diagnostic evaluations ons and/or treatments that are ordered or preferred by these professionals in available and will be provided to all individuals regardless of age, sex, race, co. At any time while on the premises of Eye Care Physicians & Surgeon, PC in the Physicians & Surgeons, PC or their employees to provide or obtain such med der the circumstances. I consent to the release of my records for the purpose as which may include but are not limited to review by the authorized representation of my records or any necessary audits within Eye Care Physicians & Surgeons assed to referral sources. I understand that my records are the property of Eye assed to referral sources. I understand that my records are the property of Eye	their olor, ne lical of tative
Patient's Signature:	Date :	
Lucas einen the Notice of Drive su Drestice	PRACTICE INFORMATION/HIPAA	
-	along with the Practice Information Sheet.	
Patient's Signature:	Date :	
Eye Care Physicians & Surgeons, PC	Date:	
Witness:		

HIPAA PATIENT NOTIFICATION RECEIPT AND FAMILY ACCESS TO PROTECTED HEALTH INFORMATION

Patient full name:	Today's date:	
Patient date of birth/		
health history, symptoms, examinations and test understand that this information serves as a base communication among the many health profess applying my diagnosis and surgical information	are Physicians & Surgeons, PC originates and maintaint results, diagnoses, treatment, and any plans for futures for planning and carrying out medical care and treatment to my bill; a means by which third party payers can care operations such as quality assurance, audits and	are care or treatment. I atment; a means of nent; a source of information for verify that services were
Information uses and disclosures. I understand amendment of my Protected Health Information & Surgeons, PC is not required to agree to any	of Information Practices that provides a complete dethat I have the right to complain, consent, object, reson. I understand that all such requests must be in writing corrections or restrictions that I may request. I under to the extent that Eye Care Physicians & Surgeons	trict and/or request correction or ng and that Eye Care Physicians stand that I may revoke any
ACCESS TO PATIENT CARE AND PROT I hereby give permission to the person(s) listed information by telephone, the party calling the	to inquire about information regarding my medical of	care. In order to obtain
Name	Relationship	
In addition:		
	Surgeons, PC may call home or other designated looppointment, labs/test, insurance/billing items, forms,	
	Care Physicians & Surgeons, PC to use and discloson previous page to act on my behalf for healthcar	-
For specific information, I am aware I will need information being released, as specified in the I	d to complete the Consent to Release Protected He s HIPAA Notice of Information Practices.	alth Information form, prior to
I may revoke this authorization in writing at an	y time.	
PRINT NAME		
SIGNATURE OF PATIENT OR LEGAL GUA	ARDIAN	DATE



ECPS Woodstock 103 W. South St. Woodstock, VA 22664

History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety Hepatitis
Arthritis Hypertension
Artificial joints HIV/AIDS

Asthma Hypercholesterolemia
Atrial fibrillation Hyperthyroidism
BPH Hypothyroidism

Bone Marrow Transplantation

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Lung Cancer

Lymphoma

Pacemaker

Prostate Cancer

Radiation Treatment

Diabetes Seizures End Stage Renal Disease Stroke

GERD Valve Replacement

Hearing Loss None

Other

Past Surgical History: (Please circle all that apply)

Appendix Removed Kidney Biopsy

Bladder Removed (Right, Left)

Mastectomy (Right, Left, Bilateral) Kidney Stone Removal Lumpectomy (Right, Left, Bilateral) Kidney Transplant

Breast Biopsy (Right, Left, Bilateral)

Ovaries Removed: Endometriosis

Breast Reduction Ovaries Removed: Cyst

Breast Implants Ovaries Removed: Ovarian Cancer Colectomy: Colon Cancer Resection Prostate Removed: Prostate Cancer

Colectomy: Diverticulitis Prostate Biopsy

Colectomy: IBD TURP
Gallbladder Removed Skin Biopsy

Coronary Artery Bypass Basal Cell Cancer Surgery

PTCA Squamous Cell Carcinoma Surgery

Mechanical Valve ReplacementMelanoma SurgeryBiological Valve ReplacementSpleen Removed

Heart Transplant Testicles Removed (Right, Left,

Joint Replacement, Knee (Right, Left, Bilateral)

Bilateral) Hysterectomy: Fibroids

Joint Replacement, Hip (Right, Left, Hysterectomy: Uterine Cancer

Bilateral) None

Joint Replacement within last 2 years

Other _____

Ocular History: (Please circle all that apply)



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Allergic conjunctivitis

Blepharitis

Cataract (Left eye, Right eye) Corneal dystrophy (Left eye, Right

eye)

Diabetic retinopathy, background

(Left eye, Right eye)

Drv eves

Glaucoma (Left eye, Right eye)

Macular degeneration (Left eye, Right

eye)

Other

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 eve, Right eve)

Vitrous floaters (Left eye, Right eye)

None

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 Heart disease

Cancer Macular degeneration

Cataracts Migraine

CVA Retinal detachment

Diabetes Strabismus

Glaucoma

Other

ARE YOU UNDER HOSPICE CARE AT THIS TIME? _____



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Medications : (Please list all current medications with dosage and frequency or write NONE)	
	_
	_
Allergies: (Please enter all allergies or write NONE)	
	_
	_



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Social History: (Please circle all that apply)

Cigarette Smoking (Please Circle):

Never smoked Quit: former smoker Smokes less than daily Smokes daily

Illicit Drug Use (Please Circle):

Drug Use IV Drug Use

Alcohol Use (Please Circle):

Alcohol: none

Alcohol: less than 1 drink a day

Alcohol: 1-2 drinks a day

Alcohol: 3 or more drinks a day

Safety (Please Circle):

I feel safe at home.

I do not feel safe at home.

Other_				
_				

None