



103 W. South St.
Woodstock, VA. 22664

158 Front Royal Pike
Suite 303
Winchester, VA. 22602

(540) 409-5254 Office * (540) 409-5253 Fax

Financial Policy

- (initial) _____ We make every effort to provide prompt medical care to each of our patients. Effective September 1, 2012, 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 \$25.00. This pertains to appts scheduled Mon-Fri.
- (initial) _____ Effective September 8, 2014, Eye Care Physicians & Surgeons, PC, will offer Saturday appointments. If you are unable to keep your scheduled Saturday appointment, a 48 hour notice to cancel is required. If proper notification is NOT received within 48 hours, I understand I will be charged a "no-show" fee of \$50.00.
- (initial) _____ If there is an identified pattern of no-shows, defined as three (3) or more consecutive times within one (1) year, I understand I may 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 account 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 in addition to a \$35.00 service charge.

* All fees/charges quoted above are subject to change at any time, and without prior notification.

Patient Signature

Date

Patient Registration Information

Date: _____

Patients First Name _____ Middle Initial _____ Last Name _____

How would you like our staff to address you? _____

Date of Birth ____/____/____ Age ____ Sex ____

Mailing Address _____ City _____ State ____ Zip _____

If different, full street address _____ City _____ State ____ Zip _____

Home Phone () _____ - _____ Cell Phone () _____ - _____

Best Time to Call _____ Email Address _____

SSN ____/____/____ Marital Status _____

Preferred Pharmacy _____ City/State _____

How did you hear about us? _____

If Referred by PCP/Medical Doctor please provide name of PCP/Medical Doctor _____

Employer _____ Phone () _____ - _____

Full Time, Part Time Occupation or school name _____

Emergency contact name: _____ **Relationship to Patient** _____ **Phone()** _____ - _____

Complete this section below only if a spouse, parent, guardian is primary insured or secondary insured or other responsible party for the account:

Responsible Party's Name _____ **Date of Birth** ____/____/____ **Age** ____ **Sex** ____

If different address from patient, please provide information below.

Address _____ City _____ State ____ Zip _____

Home Phone () _____ - _____ Cell Phone () _____ - _____

Employer _____ SSN _____

Full Time/ Part Time Occupation / Retired _____

Primary Insurance _____ **Primary Insured name** _____

Primary Insured date of birth _____ **Primary Insured SSN** _____

Group # _____ **ID** _____

Secondary Insurance _____ **Secondary Insured name** _____

Secondary Insured date of birth _____ **Secondary Insured SSN** _____

Group # _____ **ID** _____

Relationship of patient to the policyholder: SELF SPOUSE PARTNER CHILD OTHER (please circle answer)

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

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.

Patient's Signature: _____ Date : _____

HMO OR PPO PATIENTS

If any services are performed in our office and prior authorizations have been obtained, I am responsible for any deductions or co-pays that are generated from their out of network benefits.

Patient's Signature: _____ Date : _____

General Informed Consent

I authorize the staff of Eye Care Physicians & Surgeons, PC to carry out all procedures ordered by my physician. I request outpatient treatment from professionals at Eye Care Physicians & Surgeons, PC and consent to all: diagnostic evaluations, therapy services, diagnostic tests, medications and/or treatments that are ordered or preferred by these professionals in their judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion, or handicap. At any time while on the premises of Eye Care Physicians & Surgeon, PC in the event of an emergency, I authorize Eye Care Physicians & Surgeons, PC or their employees to provide or obtain such medical treatment as may be deemed advisable under the circumstances. I consent to the release of my records for the purpose of billing, treatment and healthcare operations which may include but are not limited to review by the authorized representatives of my insurance carriers the review of my records or any necessary audits within Eye Care Physicians & Surgeons, PC, and for summary information to be released to referral sources. I understand that my records are the property of Eye Care Physicians & Surgeons, PC.

Patient's Signature: _____ Date : _____

PRACTICE INFORMATION/HIPAA

I was given the Notice of Privacy Practices 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 ____/____/_____

PATIENT NOTIFICATION RECEIPT

I understand that part of my healthcare, Eye Care Physicians & Surgeons, PC originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among the many health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided; and a tool for routine health care operations such as quality assurance, audits and assessments.

I have been provided with the **HIPAA Notice of Information Practices** that provides a complete description of Protective Health Information uses and disclosures. I understand that I have the right to complain, consent, object, restrict and/or request correction or amendment of my Protected Health Information. I understand that all such requests must be in writing and that Eye Care Physicians & Surgeons, PC is not required to agree to any corrections or restrictions that I may request. I understand that I may revoke any consent that I may have given, in writing, except to the extent that Eye Care Physicians & Surgeons, PC has already taken action in reliance thereon.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

I hereby give permission to the person(s) listed to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share date of birth.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

In addition:

With this authorization, Eye Care Physicians & Surgeons, PC may call home or other designated location and leave a voice mail message, in person or by mail in reference to appointment, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

By signing this form, I am authorizing Eye Care Physicians & Surgeons, PC to use and disclose my Protected Health Information to the individuals I have listed on previous page to act on my behalf for healthcare information.

For specific information, I am aware I will need to complete the **Consent to Release Protected Health Information form**, prior to information being released, as specified in the HIPAA Notice of Information Practices.

I may revoke this authorization in writing at any time.

PRINT NAME _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____

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	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	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	Kidney 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 Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None
Other _____	

Ocular History: (Please circle all that apply)

Allergic conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal dystrophy (Left eye, Right eye)
Diabetic retinopathy, background (Left eye, Right eye)
Dry eyes
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 eye, Right eye)
Vitreous 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)
Other _____

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

Family History: (Please circle all that apply—which family member)

Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Other _____

Heart disease
Macular degeneration
Migraine
Retinal detachment
Strabismus
None

ARE YOU UNDER HOSPICE CARE AT THIS TIME? _____

ECPS Winchester
158 Front Royal Pike
Suite 303
Winchester, VA 22602



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

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

Allergies: (Please enter all allergies or write NONE)

ECPS Winchester
158 Front Royal Pike
Suite 303
Winchester, VA 22602



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

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