CROZET EYE CARE, OPTOMETRISTS OFFICE POLICY

Name:_____ **Date of Birth:**_____

PREVENTATIVE SCREENINGS

Crozet Eye Care wants to provide our patients with the highest quality care available. In our office, we utilize Optomap® retinal imaging and the iVue iWellness scan. Each provide invaluable information for early detection of disease. Our doctors want all patients to have Optomap® and iWellness. The fee is **$45** and is not covered by insurance. **I understand that by initialing this form, I am authorizing these scans to be performed.** **I have read and understand the above (Initials)** _____

CONTACT LENS PATIENTS

Please be aware that the fitting or evaluation of contact lenses is performed in addition to your eye exam and there is a separate fee for this service. The fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. **It may not be covered by insurance.** **I have read and understand the above (Initials)** _____

FINANCIAL POLICY

As a courtesy to you, we will submit the billing for today's services to your insurance carrier, if we are a participating provider for that plan. Any balance not paid by your insurance carrier is your responsibility, and you will receive a statement for payment. Unless prior arrangements are made, full payment is due at the time of service. We accept Cash, Check, Mastercard, Visa and CareCredit. Copayments and an estimate of what your insurance will not cover will be collected at the time of your appointment.
I understand that a finance charge will be applied to all accounts that are 60 days past due. For delinquent accounts, I agree to be responsible for any reasonable collection fees incurred by Crozet Eye Care, Optometrists to collect payment for materials and/or services rendered. I understand that if the account is not paid within 90 days from receipt of first statement, the amount will qualify for placement with our outside collection agency. **I have read and understand the above (Initials)** _____

APPOINTMENT POLICY

In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged $50.00 for each appointment that was missed or not canceled with 24 hours notice. **Crozet Eye Care, Optometrists makes every effort to accommodate patients, however I understand that if I am late for an appointment, I may be asked to reschedule.**
I have read and understand the above (Initials) _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that the privacy practices of Crozet Eye Care, Optometrists are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I may view and/or print a copy of this Act at my convenience by visiting www.crozeteyecare.com. I also understand that I may request a copy of this Act from the front office staff.
I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to Crozet Eye Care's use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. Insurance claim information is transmitted via secure internet connection. Crozet Eye Care may also send me mail correspondence, such as recall notices, appointment reminders and more listed below.

I prefer for Crozet Eye Care to notify or contact me the following ways:

Appointment Reminders/Confirmations/Notifications	☐ **Text**	☐ **Email**	☐ **Phone Call**
Eyewear Notifications	☐ **Text**	☐ **Email**	☐ **Phone Call**

Signature: _____ **Date:**_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

FOR OFFICE USE ONLY

I have had full opportunity to read and consider the contents of the Consent form and Notice of Privacy Practices. I do not give my consent to disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ Date: _____

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Welcome to Crozet Eye Care!

All information provided below will remain confidential and will be used only in accordance with HIPAA regulations.

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Rev. ❑ Dr. Date _____

Patient Name _____ Nickname _____ Date of Birth _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Work Phone _____ Cell Phone _____ Employer/School _____ Occupation/Grade _____

Social Security Number _____ Spouse/ Parent name _____ Other family members who are patients _____

Gender: ❑ Female ❑ Male

Email Address _____

Race:
❑ African American ❑ American Indian ❑ Arab ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Indian ❑ Multiracial

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Preferred language: ❑ English ❑ Spanish ❑ Other _____

Primary Care Physician and Address _____

Emergency Contact Name _____ Phone _____ Relationship _____

How will you settle your account today? ❑ Cash ❑ Check ❑ Credit card

If minor, who is responsible for account? _____ Relationship to patient _____

Insurance Information

Primary Medical Insurance _____ Vision Insurance _____

Subscriber Name/Date of Birth _____ Subscriber Name _____

Subscriber ID# _____ Subscriber ID# _____

New Patients Only

Who may we thank for referring you? _____

If not referred, how did you FIRST hear about our office?

❑ Embarq Yellow Pages ❑ YellowBook ❑ Insurance list ❑ Saw sign/ building ❑ Radio ❑ TV

❑ Newspaper (which one?) _____ ❑ Web Pages (which web site?) _____

❑ Other _____

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PATIENT CASE HISTORY

Name: _____

Date: _____

Patient History

Reason for visit: ❑ blurred vision ❑ eye pain ❑ tearing ❑ headaches ❑ floater ❑ flashes ❑ itchy eyes
❑ burning eyes ❑ double vision ❑ gritty eyes ❑ crossed eye/eye turn ❑ trouble seeing at night
❑ glare ❑ light sensitive ❑ other _____

Have you ever been diagnosed or treated for the following? (Check all that apply)

❑ cataract ❑ corneal abrasion ❑ eye infection ❑ eye injury ❑ eye surgery ❑ glaucoma
❑ iritis/uveitis ❑ lazy eye ❑ macular degeneration ❑ retinal detachment ❑ other _____

Date of Last Eye Exam _____ Last Eye Doctor _____

Do you currently wear glasses? ❑Yes ❑No
When do you wear your glasses: ❑ All of the time ❑ Reading/Near Work ❑ Driving ❑ Computer Use
Are you interested in a new pair of glasses? ❑Yes ❑No

Do you currently wear contact lenses? ❑Yes ❑No What type? _____
If you have never worn contact lenses, are you interested in finding out if they are right for you? ❑Yes ❑No

Do you work at a computer? ❑Yes ❑No (How much) _____hrs/week
Do you spend time outdoors? ❑Yes ❑No (How much) _____hrs/week
Do you want information on Laser Vision Correction Surgery? ❑Yes ❑No

❑ List all Medications: (Use back of sheet if needed.)

Name	Dosage
_____	_____
_____	_____
_____	_____

❑ Height _____

Social History

Do you drink alcohol? ❑Yes ❑No If yes, type / amount / how long: _____
Do you use recreational drugs? ❑Yes ❑No If yes, type / amount / how long: _____
Have you ever been exposed to or infected with: ❑ Never exposed ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis
Have you ever used tobacco products? ❑Yes ❑No If yes, select type, indicate amount and how long:

Check one:
- ❑ Current Every Day Smoker
- ❑ Current Some Day Smoker
- ❑ Former Smoker
- ❑ Never Smoker

Type	Amount	How Long
❑ Cigarettes	_____	_____
❑ Cigars	_____	_____
❑ Pipe	_____	_____
❑ Smokeless	_____	_____

Family History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None	_____	❑ Corneal disease	_____
❑ Blindness	_____	❑ Lazy Eye	_____
❑ Cataracts	_____	❑ Other Eye Disorders	_____
❑ Glaucoma	_____	❑ Diabetes	_____
❑ Macular Degeneration	_____	❑ Heart Disease	_____
❑ Retinal Detachment		❑ Other Hereditary Diseases	

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PATIENT CASE HISTORY

Name: _____

Date: _____

Review of Systems

Constitutional ❑ None
- ❑ Developmental disability
- ❑ Weight Loss
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma
- ❑ Cancer _____
- ❑ Other _____

Ears, Nose, & Throat ❑ None
- ❑ Upper respiratory tract infection
- ❑ Other _____

Neurological ❑ None
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Other _____

Psychiatric ❑ None
- ❑ Depression
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other _____

Cardiovascular ❑ None
- ❑ Heart disease
- ❑ Hypertension/ High Blood Pressure
- ❑ Stroke
- ❑ Vascular disease
- ❑ High cholesterol
- ❑ Other _____

Respiratory ❑ None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other _____

Gastrointestinal ❑ None
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive concern
- ❑ Other _____

Genitourinary ❑ None
- ❑ Urinary tract infections
- ❑ Kidney concerns
- ❑ STD: Herpes, Chlamydia, HIV
- ❑ Other _____

Musculoskeletal ❑ None
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Other _____

Integumentary / Skin
- ❑ Eczema ❑ None
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other _____

Endocrine ❑ None
- ❑ Type 1 diabetes
- ❑ Type 2 diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Other _____

Hem /Lymph ❑ None
- ❑ Anemia
- ❑ Leukemia
- ❑ Other _____

Allergic / Immunologic ❑ None
- ❑ Drug allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Other _____

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Please release my records to:

Crozet Eye Care, Optometrists
580 Radford Lane, Suite 101
Charlottesville, VA 22903

Fax # 434.823.7620

Signed_____Date_____

Printed Name_____

Date of Birth_____

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Release of Information Form
Authorization for Use or Disclosure of Protected Health Information

I authorize Crozet Eye Care to use and disclose my protected health information to the following individuals:

Name and Relationship to Patient:

_____

_____

_____

_____

_____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative:

_____

_____

Printed name of patient or personal representative and his or her relationship to patient.