Southwest Virginia Eye Center

Medical History Questionnaire

Patient Name: _____ Soc Sec. # _____ Date of Birth _____
Age: ____ Sex: ❑ M ❑ F Day Phone: _____ Cell: _____ Home: _____
Address: _____ City: _____ State _____ Zip_____
Occupation: _____ Employer: _____ Work Phone: _____
Email: _____ Nick Name: _____ Fax: _____
Date of Last Physical: _____ Date of Last Eye Exam: _____
Name of ❑Parent ❑Spouse: _____ Grade if Student: _____
Activities / Hobbies_____ Married: ❑No ❑Yes Children: ❑No ❑Yes #_____
Do you use a Computer? ❑No ❑Yes Do you Drive? ❑No ❑Yes
Reason for visit: _____ Referred by: _____

Insurance

Primary Insurance: _____ ID#: _____ Group #: _____
Policy Holder Name: _____ DOB: _____ SSN: _____
2nd Policy Holder Name: _____ ID#: _____ Group #: _____
Policy Holder Name: _____ DOB: _____ SSN: _____
Employer Primary:_____ 2nd: _____

Doctors

Medical Doctor: _____ Phone: _____ City: _____
Eye Doctor:_____ Phone: _____ City: _____

Medical History

Drug Allergies: ❑ No ❑ Yes: _____
Latex Allergy: ❑ No ❑ Yes Other Allergies: _____
Medical Conditions: ❑ Diabetes ❑ High Blood Pressure ❑ Pregnant ❑ Low Thyroid ❑ Stroke
❑ Heart Attack ❑ Other: _____
Eye Conditions: ❑ Cataract ❑ Macular Degeneration ❑ Glaucoma ❑ Lazy Eye: ❑ Blindness
❑ Other: _____
Eye Operations: _____
Other Operations: _____
Current Medications: _____
_____
Current Supplements: _____

Social History

❑No ❑Yes Tobacco How long / Amount _____
❑No ❑Yes Alcohol How long / Amount _____
❑No ❑Yes Drugs How long / Amount _____

Family History

Please note any family (parents, siblings, grandparents, children) history of the following conditions:

Condition	NO	YES	?	Relationship	Condition	NO	YES	?	Relationship
Cataract	❑	❑	❑	_____	Cancer	❑	❑	❑	_____
Blindness	❑	❑	❑	_____	Arthritis	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____	Diabetes	❑	❑	❑	_____
Retina Disease	❑	❑	❑	_____	Heart Disease	❑	❑	❑	_____
Macular Dis.	❑	❑	❑	_____	High Blood	❑	❑	❑	_____

Review of Systems

Do you or have you had trouble with the following

Condition	NO	YES	Details	Condition	NO	YES	Details
General Health	❑	❑	_____	Ears	❑	❑	_____
Nose	❑	❑	_____	Throat	❑	❑	_____
Heart	❑	❑	_____	Lungs	❑	❑	_____
Digestive	❑	❑	_____	Urinary/Bladder	❑	❑	_____
Arthritis	❑	❑	_____	Muscles/Joints	❑	❑	_____
Headaches	❑	❑	_____	Nerves	❑	❑	_____
Stroke	❑	❑	_____	Anemia	❑	❑	_____
/Lymphoma	❑	❑	_____	Allergies	❑	❑	_____
Diabetes	❑	❑	_____	Thyroid	❑	❑	_____
Skin	❑	❑	_____	Free Bleeder	❑	❑	_____
Psychiatric	❑	❑	_____	Other	❑	❑	_____

Other

Please list any other medical conditions or issues you may have or that may be important to your eye exam.

_____

_____

_____

_____

Thank you for taking the time to help us help you.

_____ _____

Patient Signature Date

Southwest Virginia Eye Center

Privacy Policies and Consent

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Age: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, specifically Gateway EDI; (2) our submission of claims to third-party or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment processes. Other areas in which your information may be disclosed include: affiliated covered entity (hospital), as required by law (FDA, public health, workers compensation, military authorities, national security, law enforcement, and CDC), and various state health agencies.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, obtain payment for our services and to perform health care operations.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but we are not obliged to agree to all requests and restrictions. If we do agree, however, the restrictions are binding on us. You may ask for a restriction when you register.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations.

_____ _____

Signature Date

Persons authorized to receive personal information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If signing as a representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Printed Name

Source of Authority: _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Southwest Virginia Eye Center Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Southwest Virginia Eye Center, PLLC
Financial Policy

While, we participate with most of the major health plans in our area, the list and the types of plans are frequently changing. Please ask if you have any questions about your specific health plan. We will verify your benefits with your insurer after we obtain the necessary information to contact the third party, and assist you in all ways possible to have your insurance pay the maximum amount allowable for your treatment.

If you have insurance for vision care or medical care, we need to know the name of your insurance company as well as any additional information necessary to file a claim. Many companies now require pre-approval or pre-authorization before eye care services are performed. **If your insurance requires pre-authorization and it is not requested prior to your eye care, the insurance company will not pay the bill and you will be responsible for the fees.**

We will file medical claims for you if your plan allows us to provide you with a medical service. (Some PPO and HMO plans will not cover you if you are seeing us out of network). It's your responsibility to know your insurance and your network.

1. Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company.
2. Even though we will file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a disputed claim. **You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.**
3. Many insurance companies will cover the charges for refractions (which is the determination of a new eyeglass or contact lens prescription); however, **Medicare will not cover this additional charge and as such, you will be responsible for this if you request to be refracted.**
4. **If your payment is denied by your bank or agent, you will also be responsible for an additional charge of twenty-five dollars ($25.00) for the added costs to collect the payment.**
5. You agree to be responsible for all costs related to any collection of your account including attorney's fees in the amount of thirty-three and one-third percent (33.3%) of the outstanding balance at the time a collection attorney contacts me, which you hereby agree is reasonable. You further agree to pay interest at the rate of one and one-half percent (1 ½%) per month on any amount due Southwest Virginia Eye Center, PLLC, which remains unpaid thirty (30) days after its due date. You further agree to allow us or collection services to contact you by telephone at any number associated with your account including wireless. You also agree you may be contact by email or text messaging which could result in charges to you depending on your phone plan.

Assignment of Benefits Authorization

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the above information on this sheet and have provided the information requested if applicable on my insurance. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance or routine vision coverage. I request that payment of authorized medical or routine vision benefits be made to Southwest Virginia Eye Center, PLLC, on my behalf for any services furnished by Southwest Virginia Eye Center, PLLC if applicable. I authorize Southwest Virginia Eye Center, PLLC to release to the health plan indicated if applicable; any information needed to determine these or benefits payable to related services.

_____ _____

Signature Date

Southwest Virginia Eye Center

Medicare Questionnaire – Federal Government Law

Patient Name: _____ Date: _____

Medicare Number: _____

Medicare law requires that we determine if another insurer might cover your medical services. In order to assist us in the correct billing of these services, please answer the following questions:

Is the injury or illness for which you seek treatment, due to:

1. A work-related accident/condition?

☐ No ☐ Yes, If yes then complete:

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

2. An Automobile Accident?

☐ No ☐ Yes, If yes then complete:

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

3. An accident other than an automobile accident?

☐ No ☐ Yes, If yes then complete:

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

4. The fault of another party?

☐ No ☐ Yes, If yes then complete:

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

5. Condition covered under the Federal Black Lung Program?

☐ No ☐ Yes

6. **Are you eligible for coverage under the Veteran's Administration?**

☐ No ☐ Yes

7. Are you employed?

☐ No Date of Retirement: _____

☐ Yes Employer Name: _____

Address: _____

8. Do you have Employer Group Health Plan Coverage?

☐ No ☐ Yes (if Yes then complete)

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

9. Is your spouse employed?

☐ No ☐ Yes (if Yes then complete)

Employer Name: _____

Address: _____

10. Are you covered under your spouse's Employer Group Health Plan?

☐ No ☐ Yes (if Yes then complete)

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

11. Are you a dependent covered under a parent's/guardian's Employer Group Health Pan?

☐ No ☐ Yes (if Yes then complete)

Name of Insurance: _____

Address: _____

Policy or ID#: _____ Accident Date: _____

Thank you for your cooperation in ensuring that your medical services will be billed to the proper insurer(s).

_____ _____

Signature Date