Charlottesville Eye Associates, Ltd.

William MacIlwaine, M.D.~Mark Gonce, M.D.~Richard Morton, M.D. ~Scott Womack, M.D.
William S. Grover, M.D.~Shannon D. Huntzberry, O.D.

DATE: _____

NAME: _____ BIRTDATE:_____
FIRST M LAST

ADDRESS:_____
street city state zip

PHONE #: home_____ work _____ cell_____

SOCIAL SECURITY #:_____ SEX: M F MARITAL STATUS: S M D W

OCCUPATION:_____ EMPLOYER:_____

EMERGENCY CONTACT:_____ CONTACT #:_____

*******PHARMACY PREFERENCE:_____**

Medical Release Authorization:

I request that payment of authorized Medicare/Medicaid/other private insurance benefits be made on my behalf to Charlottesville Eye Associates for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other applicable insurance carrier and its agents any information needed to determine these benefits payable for related services.

Patient Signature:_____ Witness:_____

Financial Policies:

We participate in a variety of medical insurance plans. However, we cannot file your insurance unless an active card is presented at every visit. **Copayment and non-covered services will be collected at the time of service.** It is your responsibility to verify if our office is an in-network provider of your insurance. If we do not participate with your insurance company, we may bill them as a courtesy but full payment is appreicated at the time of service. **If a referral or preauthorization for services is required, you are responsible for confirming this prior to receiving services.**
Our office is **NOT** a provider of any **Vision Plans**. We will be happy to give you an itemized receipt and you can file the claim to your plan.
We accept all major credit and debit cards, as well as cash or check. Payment is expected in full for all non-insured patients or for those patients unable or unwilling to provide a current insurance card.
A **$30.00** fee will be assessed on all returned checks.
Payment in full is expected for all contact lens and optical purchases.

Cancellation/No Show Policy: We understand there may be times when you may miss an appointment due to emergencies or unforeseen obligations to work or family. Please notify us **24 hours** in advance to avoid our **$25.00 fee**.

Refraction Charge: Refraction is the procedure in which we determine the best corrected visual acuity of each eye for purposes of medical evaluation and for prescribing glasses or contact lenses. Refraction is necessary to adequately determine visual function and is important in making sure that serious underlying eye problems do not exist. We perform refractions as a part of all of our comprehensive eye evaluations. We trust that you will understand the need to perform this procedure and we respectfully ask for payment at the time of service.

Collection Policy: Outstanding balances will be turned over to a collection agency with failure to pay within (2) billing cycles (60 days).

Release of Records: There will be reasonable and cost-based fee to cover the cost of copying (labor/suppy costs) and postage of the requested records.

I have read and fully understand the financial policies set forth by Charlottesville Eye Associates, Ltd. I agree to the terms of these polices and understand that the terms may be amended by the practice at anytime without prior notification to the patient.

Signature:_____ Date:_____

PATIENT HISTORY RECORD:

DATE FORM ORIGINALLY COMPLETED: _____

REVIEW OF SYSTEMS *please indicate below if you have any of the listed medical conditions:*	**Circle response below**	**If YES, please EXPLAIN in the space provided**
1. EYES (glaucoma, cataract, retinal disease, other)	**YES NO**	
2. CONSTITUTIONAL (fever, weight loss, other)	**YES NO**	
3. CARDIOVASCULAR (High BP, stroke, heart problems, other)	**YES NO**	
4. GENITOURINARY (urinary problems, UTI, other)	**YES NO**	
5. NEUROLOGICAL (weakness, paralysis, headaches, other)	**YES NO**	
6. PSYCHIATRIC (depression, anxiety, other)	**YES NO**	
7. RESPIRATORY (asthma, shortness of breath, other)	**YES NO**	
8. INTEGUMENTARY (skin rashes, skin dryness, other)	**YES NO**	
9. HEMATOLOGIC/LYMPHATIC (blood disorders, leukemia, other)	**YES NO**	
10. ENDOCRINE (diabetes, thyroid problems, other)	**YES NO**	
11. EARS/NOSE/MOUTH/THROAT (hearing loss, sinus problems, other)	**YES NO**	
12. GASTROINTESTINAL (heartburn, acid reflux, other)	**YES NO**	
13. MUSCULOSKELETAL (arthritis, joint pain, other)	**YES NO**	
14. ALLERGIC/IMMUNOLOGIC (medications, hayfever, seasonal allergies, other)	**YES NO**	

PLEASE LIST ANY PERSONAL HISTORY OF EYE SURGERY / LASER OR OCULAR INJURY:

_____

PRIMARY CARE PHYSICIAN _____ **FORMER EYE DOCTOR _____**

PAST, FAMILY AND SOCIAL HISTORY

Please indicate below if there is a* family *history of medical problems or eye disease and which relative(s) is/are affected:

Glaucoma _____
Macular Degeneration _____
Retinal Detachment_____
Cataract_____
Diabetes_____
High Blood Pressure_____
Cancer_____
Other_____

Please complete below:

Do you use tobacco products? Yes No
If so, how much? _____
Do you drink alcohol? Yes No
If so, how much? _____

Female patients only:
Are you or is there a chance you could be pregnant? Yes No