Charlottesville Eye Associates, Ltd.

DATE: ________________

NAME: ____ **BIRTHDATE:**__________________
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 #:**____________________

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 appreciated at the time of service or you will receive a balance bill. **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.

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. **Most insurances do not cover the charge and we trust that you will understand the need to perform this procedure. We respectfully ask for PAYMENT at the time of service. We can give you an itemized receipt and you can try to file to your vision plan.**

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**.

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/supply 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:

Primary Care Physician: ______________________________________

Preferred Pharmacy:____

Personal Medical Information: Do you have any problems with any of these systems?
Please Circle:

Diabetes Stroke Heart Conditions Breathing Problems

Weakness Headaches Thyroid Disease Hearing Loss

Past Eye History: Have you ever experienced any of these eye conditions?
Please Circle:

Cataracts Cornea problem Glaucoma Neurological eye problem

Injury Retina problem Lazy eye Macular degeneration

Other: ____

Currently wearing: Glasses Contact Lenses Nothing

Eye Surgery/Laser/Lasik: ______________________________________

____

Former Eye Doctor:____

Please List any Allergies: ______________________________________

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________________________
Vision Loss________________________

Pneumonia Vaccine: Y N

Covid Vaccine: Y N

Are you a:
___ Current every day smoker
___ Former smoker
___ Never smoker

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