ADULT NEW PATIENT

ARLINGTON LOUDOUN PEDIATRIC OPHTHALMOLOGY, PLLC
NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

Definition of REFRACTION: The refraction test is an eye examination that measures a person's ability to see an object at a specific distance. Dr. Kern and/or associates can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). This test helps confirm the extent of vision difficulty. The information obtained from a refraction test allows the prescription for eyeglasses or contact lenses to be correct for each person. This test can be done as part of a routine eye test to determine if a person has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to prescribe glasses if needed.

Medicare and most commercial insurance plans do not cover the above mentioned service. If Dr. Kern and/or associates determine that you need to have a refraction performed and your insurance does not pay for it, you will be held responsible for paying that portion of the exam fees along with any other fees you are normally responsible for (i.e. co-payments/deductibles).

By signing, I understand that the refraction may not be a covered service under my health insurance plan. If I want a glasses prescription update/renewal or other eye services performed today, I agree to pay any fees related to this non-covered service along with any other fees required by my insurance plans (co-payments/deductibles).

Patient Signature_____

Date of Signature:_____/_____/_____

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PATIENT INFORMATION

Last Name: _____ First Name: _____MI:_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____Sex: ☐ Male ☐ Female Age _____

Street Address: _____

City: _____State:_____Zip:_____

(Fed Govt. Requirement) Race:
☐ American Indian/ Native Alaskan ☐ Asian ☐ Black/ African American
☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Other

(Fed Govt. Requirement) Ethnicity***:*** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone :(_____) _____-_____ Work Phone :(_____) _____-_____ ext_____

Cell Phone :(____) _____-_____ Email Address:_____@_____._____

Name of Primary Physician_____ Phone :(____) _____-_____

(If referred) Name of Physician_____ Phone :(____) _____-_____

PRIMARY INSURANCE INFORMATION (Must present insurance card to our staff)

Ins Co:_____ Policy #:_____ Group#:_____

Patient's relationship to the Subscriber (if other than self include info below): ☐ Self ☐ Spouse ☐ Child

Last Name:_____ First Name:_____ MI:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address:_____

City:_____ State:_____ Zip:_____

SECONDARY INSURANCE INFORMATION (Must present insurance card to our staff)

Ins Co:_____ Policy #:_____ Group #:_____

Patient's relationship to the Subscriber (if other than self include info below): ☐ Self ☐ Spouse ☐ Child

Last Name:_____ First Name:_____ MI:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address:_____

City:_____ State:_____ Zip:_____

_____ _____/_____/_____
Patient/ Responsible Party Signature Date of Signature

ARLINGTON/LOUDOUN PEDIATRIC OPHTHALMOLOGY, PLLC

Primary Physician: _____ Phone :(___) _____-_____

Address, city/state_____

Any other doctor who should get a report: _____

Address, city/state_____

Briefly state the problem for which you are coming to the see the doctor:
_____

_____

When did the problem first develop? _____

What treatment for this problem, other than surgery, have you received in the past? (for example prisms, patching, exercises)_____

_____

Have you had eye muscle surgery in the past? Yes_____ No_____

If yes, approximate date(s)_____

Name of doctor(s) performing surgery _____

Address, city/state _____

List any other eye surgeries you have had (cataract, glaucoma, etc.):

_____

_____

List any surgeries you have had (appendectomy, tonsillectomy, etc.):
_____
_____

Present Medications (including eye medications_____

_____

Allergy to Medication _____

ARLINGTON/LOUDOUN PEDIATRIC OPHTHALMOLOGY, PLLC

SOCIAL

Occupation: _____

Marital Status: Married_____ Divorced_____ Single_____ Widowed_____

Do you drive? Yes___ No___
Have you ever had a blood transfusion? Yes___ No___ If yes, what year? _____
Do you smoke? Yes___ No___ If yes, how many packs/day? _____
If you quit, how long ago? _____
Do you drink alcohol? If yes, how many drinks/week? _____

Do you current have any of the following? If yes, please provide information.

REVIEW OF SYSTEMS	YES	NO	EXPLANATION OF PROBLEM
EYES (glaucoma, cataracts, blurred vision)			
GENERAL(fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR(chest pain, palpations)			
RESPIRATORY (cough, shortness of breath, wheezing)			
GASTROINTESTIONAL(nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
MUSCULOSKELETAL (joint pain, muscle weakness)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
HEMATOLOGIC (anemia, bleeding, bruising tendencies)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, HIV)			

Office Use Only:

History reviewed: __No Changes __Changes as above

Date:_____/_____/_____ Doctor Signature:_____

Arlington Loudoun Pediatric Ophthalmology, PLLC

HIPAA Release of Private Health Information

I hereby authorize the release of any private health information (PHI) obtained in the course of my registration, interview, examination and treatment, necessary to file or appeal any claim with my insurance carrier(s) or deemed necessary pursuant to State of Federal law, statute or regulation. I acknowledge that if I wish to have any individual or entity restricted from access to my PHI, I will notify the office in writing. (*Please ask front desk for Restricting PHI Access form).*

Assignment of Insurance Benefits & Agreement to Pay Balance Due

I hereby authorize my insurance carrier(s) to directly pay Arlington Loudoun Pediatric Ophthalmology, Pllc. Any medical/ surgical benefits otherwise payable to me by my insurance carrier(s) for services as rendered.
I also accept responsibility for paying any monies not paid by my insurance carrier(s) for a balance due to Arlington Loudoun Pediatric Ophthalmology, Pllc (including co-pays, deductibles, co-insurances, refraction fees and other carrier non-covered services), as well as pay for any balance which the carrier(s) fails to consider, except that dollar amount which is limited by participating provider agreement between Arlington Loudoun Pediatric Ophthalmology, Pllc and my insurance carrier(s).

Participation, Pre-Authorization, Referrals

I understand that I am responsible for contacting my insurance carrier(s) to confirm if Arlington Loudoun Pediatric Ophthalmology, Pllc are participating with my insurance carrier(s) and that I am eligible for benefits on or before the date my visit(s) take place. I also agree to pay and not bill my insurance carrier(s) for any claim that is past timely filing due to the fact that I did not present my correct insurance card(s) to Arlington Loudoun Pediatric Ophthalmology, Pllc before the timely filing deadline lapsed.
Furthermore, I agree to contact my insurance carrier(s) and/or Primary Care Physician to determine if it is necessary to obtain any pre-authorization/ referral before my visit(s) take place. Moreover, I agree to pay for any dollar amount denied or applied to my deductible by my insurance carrier(s), sue to the fact that I failed to present a pre-authorization/ referral at the time of my visit.

Missed Appointments and Collections

I recognize that Arlington Loudoun Pediatric Ophthalmology, PLLC reserve the right to charge me for missed appointment and appointment cancelled with less than 24 hours notice, a missed appointment fee of one hundred dollars ($100) will be charged. This fee must be paid before a new appointment is scheduled. (barring an emergency).

If at any time I have a balance due which is more than 90 days old I understand that my account may be referred to an outside collection agency without notice. If my account is sent to a collection agency, I hereby agree to pay for all collection costs incurred while collecting my debt in addition to fiancé charges at the rate of 1.5% per month.
A copy of my signature consenting to this agreement is a valid as the original, and shall continue to be valid for one year from the date of signature.

Forms & Medical Records:

There is a fee associated with copying of medical records. Please inquire at the front desk by requesting a Record Release From.

_____ _____/_____/_____

Patient/ Responsible Party Signature Date of Signature

ARLINGTON/LOUDOUN PEDIATRIC OPHTHALMOLOGY, PLLC

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment and health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we proved the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with your (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, then, at some future time, you may request this health care provider to refuse disclosure of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____Signature_____Date____/_____/_____

Arlington Loudoun Pediatric Ophthalmology, Pllc

Melissa D. Kern, MD
Tina Douroudian, OD
46161 Westlake Drive #300
Sterling, VA 20165

No Show Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$100 no show fee**. You must give **24 hour advanced notice to cancel appointments**. Failure to do so will result in a $100 fee charged to your account.

By signing below, I acknowledge that I have read and understand this policy.

Patient/ Responsible Party Signature:_____

Patient Name (printed): _____

Date: _____

ARLINGTON/LOUDOUN PEDIATRIC OPHTHALMOLOGY, PLLC

ALERT: PLEASE ALLOW 2 HOURS FOR YOUR APPOINTMENT

INFORMATION ABOUT DILATION

DILATING DROPS ARE NECESSARY SO THAT THE OPHTHALMOLOGIST CAN GET A GOOD LOOK AT THE INNER EYE STRUCTURE TO MAKE SURE THE EYE IS HEALTHY. MANY EYE DISEASES MAY NOT MANIFEST SYMPTOMS BUT CAN BE DETECTED WITH DILATION.

DILATING DROPS ARE MEDICATION USED TO MAKE THE PUPILS BIGGER IN ORDER TO GET A BETTER VIEW OF THE INTERNAL STRUCTURES OF THE EYE.

DILATING DROPS USUALLY TAKE 20-30 MINUTES TO START WORKING. WHILE DILATING DROPS ARE WORKING, YOU WILL SENSITIVE TO LIGHT AND MAY NOTICE DIFFICULTY FOCUSING ON OBJECTS UP CLOSE.

THESE EFFECTS CAN LAST FOR SEVERAL HOURS DEPENDING ON THE STRENGTH OF THE DROPS USED.

DILATION IS VERY IMPORTANT FOR PEOPLE WITH RISK FACTORS FOR EYE DISEASE.

Print Name_____Signature_____Date___/___/_____