

Arlington Loudoun Pediatric Ophthalmology, LLC

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

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

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: _____ @ _____ . _____

(if child) Name of Pediatrician _____ 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: _____

_____ / _____ / _____

Responsible Party Signature

Date of Signature

Arlington Loudoun Pediatric Ophthalmology, LLC

If **ADOPTED** and you do not have any of the following information **PLEASE CHECK HERE** ☐

Reason for today's visit: _____

List any medications **PATIENT** is currently taking:

Allergies to Medications: _____

Other Allergies: _____

Medical Problems:

PATIENT'S BIRTH HISTORY:

BIRTH WEIGHT: _____ OXYGEN THERAPY AT BIRTH: Y N

PREMATURE: Y N If yes, how many weeks: _____

INFECTIONS OR OTHER MEDICAL PROBLEMS AT BIRTH: Y N If yes, _____

ANY FAMILY HISTORY OF THE FOLLOWING (CIRCLE Y FOR YES AND N FOR NO):

STRABISMUS Y N

GLAUCOMA Y N

(LAZY MUSCLE)

If yes, who? _____

If yes, who? _____

AMBLYOPIA Y N

COLOR BLIND Y N

(LAZY VISION)

If yes, who? _____

If yes, who? _____

MYOPIA Y N

ASTIGMATISM Y N

If yes, who? _____

If yes, who? _____

CATARACTS Y N

ANOTHER EYE DISEASE Y N

If yes, who? _____

If yes, who? _____

Have any Brother's OR Sister's been seen at our office?

Name of Siblings: _____

ARLINGTON LOUDOUN PEDIATRIC OPHTHALMOLOGY, LLC

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 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 noncovered service along with any other fees required by my insurance plans (copayments/deductibles).

Patient / Responsible Party Signature_____

Date of Signature: _____

ARLINGTON LOUDOUN PEDIATRIC OPHTHALMOLOGY, LLC

ALERT: PLEASE ALLOW 2 HOURS FOR YOUR APPOINTMENT

INFORMATION ABOUT 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 to 30 minutes to start working. While dilating drops are working, your child will be sensitive to light and may notice difficulty focusing on objects up close.
- These effects can last for several hours even up to three days in some children depending on the strength of the drops used.
- Dilation is 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. These drops also temporarily relax a child's focusing power so that any refractive error can be accurately measured.

Patient / Responsible Party Signature_____

Date of Signature: _____

Arlington Loudoun Pediatric Ophthalmology, LLC

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 **\$75 no show fee**. You must give **24-hour advanced notice** to cancel appointments. Failure to do so will result in a \$75 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, LLC

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, LLC/ Arlington Eye Center, Inc. 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, LLC/ Arlington Eye Center, Inc. (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, LLC/ Arlington Eye Center, Inc. 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, LLC/ Arlington Eye Center, Inc. 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, LLC. / Arlington Eye Center, Inc. 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), due 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, LLC/ Arlington Eye Center, Inc reserve the right to charge me for missed appointments and appointments cancelled with less than 24 hours' notice, a missed appointment fee of seventy-five dollars (\$75) 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 finance charges at the rate of 1.5% per month.

A copy of my signature consenting to this agreement is as 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 Form.

Patient/ Responsible Party Signature

_____/_____/_____
Date of Signature

Arlington Loudoun Pediatric Ophthalmology, LLC

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, or 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 provide 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 you (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.

Patient Name: _____

Patient/ Responsible Party Signature: _____ **Date:** _____