RICHMOND EYE ASSOCIATES, P.C.

BARRY E. ROPER, M.D.
D. ALAN CHANDLER, M.D.
MALCOLM MAGOVERN, M.D.
HAROLD A. BERNSTEIN, M.D.
DAVID M. BOWMAN, M.D.
BRYAN M. BROOKS, M.D.
DONALD W. LUMPKIN, JR., O.D.
CINDY KOZA, O.D.

Welcome to Richmond Eye Associates!

Thank you for choosing Richmond Eye Associates for your eye care needs.

Our goal is to provide you with the finest eye care possible. For your convenience, Richmond Eye Associates offers full-service eye care at three locations in the Richmond area. All of our ophthalmologists are board certified or board eligible by the American Board of Ophthalmology.

Our optometrists have membership in the American Optometric Association. Licensed opticians will help you in our three optical dispensaries with new or replacement frames and lenses, adjustments at no charge, and quality guaranteed service at competitive prices.

To make your initial visit with us as pleasant, convenient, and time efficient as possible, please complete these forms at home before your appointment. Driving directions to all our offices are available.

We have also included a summary of our Privacy Policy with an acknowledgement form for your signature. Our Privacy Policy, in its entirety, is available in our office or online. Please call us at (804) 270-0330, or toll free at (800) 707-0330 if you have any questions.

Please bring your Insurance Cards and Referral (if required by your insurance) on the day of your appointment.

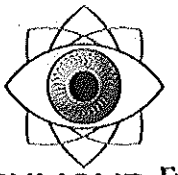
We look forward to seeing you for your appointment. Again, if we can assist you in any way, please call.

Please note that failure to provide 24 hours' notice of cancellation will result in a $40 charge.

Sincerely,

Richmond Eye Associates, P.C.

Version 2014:03



RICHMOND EYE ASSOCIATES, P.C.

In accordance with 2014 ACA (Affordable Care Act) requirements please kindly provide the following information

DATE: _____

LAST NAME:_____ FIRST NAME: _____ M.I. _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

SSN: _____GENDER: M ____ F ____ MARITAL STATUS: S M D W

DATE OF BIRTH: _____ AGE: _____

PLEASE CIRCLE YOUR ETHNICITY: African American Asian Caucasian Hispanic Indian Native American Latin American Mexican Other/Not Stated

EMPLOYER: _____

FAMILY DOCTOR: _____ REFERRING DOCTOR: _____

PRIMARY INSURANCE: _____

INSURED NAME: _____ INSURED DOB: _____ INSURED SSN: _____

INSURED EMPLOYER: _____

SECONDARY INSURANCE: _____INSURED NAME: _____

EMERGENCY CONTACT? _____ PHONE: _____

IF PATIENT IS A MINOR, THE FOLLOWING MUST BE COMPLETED BY THE PARENT OR GUARDIAN

PARENT/GUARDIAN NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY NUMBER: _____

****** PLEASE SEE OTHER SIDE ******

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MEDICAL SERVICES CONTRACT

I hereby authorize and consent to medical treatment by Richmond Eye Associates, P.C. for me (or my child). I authorize Richmond Eye Associates, P.C. to release my (or my child's) medical information to my (or my child's) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Richmond Eye Associates, P.C. or other authorized party.

I understand that I am responsible for payment of all medical treatment rendered to me (or my child) by Richmond Eye Associates, P.C., and I agree to pay all co-payments, deductibles and non-covered services in full at the time of the visit. In the event that I am seen at any time by a Richmond Eye Associates, P.C. physician without a required referral, I understand that I am financially responsible for all charges incurred. Vision plan information presented after the date of service will not be accepted. A fee of $30.00 will be charged for all returned checks.

I understand that, as a courtesy to me, Richmond Eye Associates, P.C., will file a claim with my (or my child's) insurance carrier, and I authorize payment directly to Richmond Eye Associates, P.C. for the benefits otherwise payable to me under the terms of my (or my child's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier. In the event that I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees in the amount of thirty-three and one-third percent (33 1/3%) of the amount due at the time the account is turned over for collection plus court costs and any additional collection fees.

"Refraction" - the determination of the best corrective lenses to be prescribed or a change in your glasses prescription (CPT code 92015) is a separate charge in addition to an eye exam. Most insurance companies consider this to be a "non-covered" or not "medically necessary" service. I understand that I am financially responsible for all services denied by my insurance for these reasons.

Pupil dilation may make you more sensitive to sunlight. We will be happy to provide a complimentary pair of disposable sunglasses. If you feel that your driving may be impaired, please discuss this with the doctor prior to dilation.

_____ _____

Signature of Patient, or Guarantor if Patient is a Minor or Child **Date**

Patient History Record

Date:_____ Whom may we thank for referring you to our office? _____

Patient Name:_____ Birthdate: _____

Occupation:_____ Personal Physician: _____

Optometrist:_____ Referring Physician: _____

What brings you in to see us today? _____

Please answer the following questions about your medical status and history:

Please circle any of the following that you are being treated for or have been treated for in the past:

Diabetes	Strabismus	Retinal disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	
Other: _____	Other: _____	

Have you ever had any eye surgery or other surgery?
No____If YES, Please explain: _____
Do you take any medications?
No____If Yes, Please list: _____
Do you take any eye drops or medications for your eyes?
No____If YES, Please list: _____
Do you have any drug or food allergies?
No____If YES, Please Explain: _____

Please circle any of the following problems that you are currently experiencing, or have experienced in the past:

Chronic fever	Vomiting	Irregular Heartbeat
Joint Pain	Abdominal	Urinary pain or discomfort
Blood in urine	Skin rashes	Excessive dry skin
Diarrhea	Shortness of breath	Numbness
Fatigue	Wheezing	Weakness
Hearing loss	Coughing	Paralysis
Sinus problems	Muscle aches	Anxiety
Sore throat	Swollen joints	Heartburn
Chest pain	Unexpected weight loss/gain	Headaches

Has anyone in your family ever been diagnosed with any of the following? Please circle.

Diabetes	Strabismus	Retinal disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	
Other: _____	Other: _____	

Do you smoke? If Yes, how much? _____

Drink alcohol? If Yes, how much?_____

Do you wear contact lenses? No: _____ Yes: _____

If Yes what type?_____Soft lenses_____Rigid gas permeable lenses_____Hard lenses

What Brand? _____

How often do you throw them away? _____

How many years have you worn contact lenses? _____

Do you sleep in your contacts?_____No_____Yes: How often? _____

What supplies or solutions do you use to take care of your contact lenses? _____

Do you wish to be fit for contact lenses or renew your contact lens prescription?

_____No _____Yes

IMPORTANT: For a Contact Lens Fitting or Contact Lens Prescription Renewal, there will be a fitting charge in addition to the standard examination fee that may or may not be covered by your insurance plan. Patient is responsible for any of these charges not covered by your insurance. These fees will be due at the time of service. Please speak to your insurance provider regarding complete details on this.

Please be sure to bring your Medications (or list of medications), Glasses and/or Contact Lenses with you.

Signed:_____Date: _____

Patient Privacy Notice Summary

Our commitment to Protecting Your Privacy and Earning Your Trust

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you. The protection of your privacy is a key part of maintaining your trust. This has been a fundamental operating principle of Richmond Eye Associates since our founding and remains so today. This Patient Privacy Notice Summary lets you know the information we collect about you, and how we safeguard and use this information to serve you.

Information We Collect About You

We collect nonpublic information about you from the following sources:

- Information you provide directly to use upon registration including financial contracts.
- Information we obtain from others to verify information provided by you, such as your insurance policy information and health history.

Richmond Eye Associates only collects and uses patient information that is necessary to render our procedures, provide superior service, and make you aware of services that we believe will be a benefit and value to you.

Information We Disclose to Others

We do not disclose any nonpublic, personal information about our patients or former patients to non-affiliated third parties, without written consent form the patient. Richmond Eye Associates is concerned about you and your privacy, and carefully limits and controls the patient information we share with others. We do not disclose information about our current (active or inactive) patients to anyone, except as outlined in this notice or as permitted or required by law.

Our Security Procedures and Our Pledge to You

Richmond Eye Associates is committed to protecting the security of our patient information. We maintain strict internal policies regarding confidentiality of patient information for both our current and former patients. We limit access to this information to only those employees who need it in order to perform their jobs. We maintain physical, electronic, and procedural safeguards that comply with federal guidelines to safeguard patient information. Our employees are bound by our policies to access patient information only for legitimate clinical and/or business purposes and to keep such information confidential at all times. We pledge to do all we can to protect your privacy. If you have any questions about our Privacy Policy, or about how your information is maintained, safeguarded, or used, please contact our Privacy Officer at (804) 270-033. To read our full Privacy Policy, go to Notice of Privacy Practices at www.richmondeye.com

Richmond Eye Associates, P.C.

Notice of Privacy Practices
Written Acknowledgement Form

I, _ , (Print Patient Name)
have been provided a copy of Richmond Eye Associates' Notice of Privacy Practices and I have had an opportunity to read the notice. (See back of page.)

I authorize you to release my personal health information to the following individual(s). Please print. You may list as many individuals as you wish.

Name:	**Relationship:**	**Gender:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand I may change this list at any time.

_____ _____
Patient Signature Date

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PHYSICIAN NOTICE TO MEDICARE PATIENTS

Medicare program standards under section 1862 (a) (a) of the Medicare law will deny payment for:

"Refraction - the determination of the best corrective lenses to be prescribed or a change in your glasses prescription (CPT Code 92015),"

For the following reason:

NON COVERED SERVICE

BENEFICIARY AGREEMENT

I have been notified by my physician that he / she believes that in my case, Medicare will deny payment for refraction for the reason stated above. I agree to be personally and fully responsible for the payment.

(Refraction fee is $35.00 as of 1/1/14).

_____ _____

Beneficiary Signature **Date**