RICHMOND EYE ASSOCIATES, P.C.

Patient Registration Form

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

Date: _____

Last Name: _____ First Name: _____ M.I._____ Circle Male / Female

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Marital Status: Circle S M D W SSN_____

Birthdate: _____ Age: _____

Please circle your ethnicity: African American Asian Caucasian Hispanic Indian Native American Latin American Mexican Other/Not Stated Refuse to Comment

Family Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____ Employer: _____

Primary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

Secondary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

Emergency Contact: _____ Phone: _____

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

Parent/Guardian Name: _____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

RICHMOND EYE ASSOCIATES, P.C.

MEDICAL SERVICES AGREEMENT

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. I understand that insurance authorizations are an estimation of coverage, and that final out of pocket amounts may vary based on actual insurance payment. Vision plan coverage must be presented prior to or at the time of service. 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, either a paper claim or an electronic claim, whichever is required by 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 a "non-covered" service. This service, while not covered by most insurance companies may be needed for your physician to determine the cause of any changes in your vision, therefore making it a **necessary** part of the examination and not optional.

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 minor child Date

Richmond Eye Associates, P.C.

Notice of Privacy Practices
Written Acknowledgement Form

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

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:** (Son, daughter, spouse)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand I may change this list at any time.

_____ _____

Patient Signature Date

*Full version of Richmond Eye Associates' Notice of Privacy Practices may be found on our website: www.richmondeye.com

Richmond Eye Associates, P.C.

Patient History Record

Patient Name:_____ Date:_____

Referring Doctor:_____ Family Doctor:_____

Have you ever had any eye surgery?

No ___ If YES, please explain:_____

Do you take any eye drops or medications for your eyes?

No ___ If YES, please list:_____

Please list any other medications:_____

Do you have any drug allergies?

No ___ If YES, please list all your drug allergy and the allergic reaction to that drug:_____

_____

_____

_____

Are you / could you be pregnant? Yes / No Are you currently nursing? Yes / No

Please circle any of the following that your family has ever been diagnosed with:

Blindness	Macular Degeneration	Strabismus
Glaucoma	Cancer	Retinal Disease
Other:		None

Do you smoke? No ___ Former Smoker?___ If YES, how much?_____

Do you drink alcohol? No ___ If YES, how much? _____

Please be sure to bring your glasses and/or contact lenses with you.