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Welcome to Virginia Eye Center, PC! We are delighted that you have selected Virginia Eye Center for your eye care needs. We look forward to seeing you at your upcoming appointment.

Before Your Appointment

- Please complete the Patient Registration, Medical Questionnaire and Consent to Dilate and Refract forms attached. You may bring them to your appointment or fax them to us beforehand at 703.858.9801. If you have an appointment for a cataract surgery consult, there are additional forms located on our website that we request be completed.
- If you wear contact lenses, please review and complete an additional form on our website for new or established wearer.
- Please verify with your health insurance company if a referral from your primary care physician is required. We are considered a specialist under your medical insurance plan. We do **NOT participate with vision insurance plans**.
- If you need to cancel or reschedule your appointment, we request at least 24 hours' notice, or else a fee may be charged. Please call 703.858.9800 if you need to reschedule your appointment.

Day of Your Appointment

- Bring your completed paperwork and plan to arrive 15 minutes before your scheduled appointment time to complete the registration process.
- Bring a Photo ID and your current health insurance card(s). We do **NOT** participate with vision insurance plans.
- If required by your health insurance company, bring a referral from your primary care physician.
- If you wear contact lenses, bring your contacts, and box, if available.
- Bring any pairs of glasses you currently wear.
- Co-pays are due at the time of your appointment, as well as payment for any services that are not covered by your health insurance plan, such as refraction. Our office fee for a refraction is \$60.00.
- If you are having a comprehensive eye exam or cataract surgery consult, please plan to be in our office for about 2 hours.

As part of your appointment, your pupils may be dilated. Dilation frequently changes vision for a length of time which varies from person to person, but could last as long as 3-4 hours. Potential side effects include glare, blurred vision, decreased contrast threshold which may make you more susceptible to falls and light sensitivity. Sunglasses are available in our office after your appointment.

Please do not hesitate to contact our office at 703.858.9800 or www.vaeyecenter.com if you have any questions or need additional information.



WELCOME TO OUR OFFICE

Today's Date _____

Thank you for choosing us for your eye care needs.
In order to serve you properly, please print the following information and sign below.

First Name MI Last Name Date of Birth Sex Marital Status: M F S M W D

Street Address/City/State/Zip

Home Phone# Personal Cell Phone # Work Phone # Fax#

Employer/Occupation May we contact you at your place of employment? Yes No

Social Security# (Confidential) May we leave detailed messages? Yes No
May we leave automated reminder call messages on your cell/home phone? Yes No

Email address (For appointment reminders, news, promotions)

REQUIRED BY FEDERAL GOVT TO INQUIRE: Language: English Other
Race: White Asian Black/African American American Indian/Alaska Native Native Hawaiian or Other Pacific Islander Other Decline
Ethnicity: Not Hispanic/Latino Hispanic/Latino Decline

Pharmacy Name Pharmacy Address Pharmacy Phone#

Insurance Subscriber Name Date of Birth Relation: Self Spouse Parent/Guardian

Parent/Guardian Full Name (for patients under 18 years of age)

Name of Person Financially Responsible for this Account/Relation Social Security # Phone#

Name of Person(s) you'd like to Authorize to Receive/Discuss Medical/Financial Info Relation to Patient

In Case of Emergency, Contact Name & Relation Phone#

How did you hear about us? Primary Care/Other Dr. Name:
Insurance Website Internet Search (website name)
Family/Friend Referral Name Other

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage or status. I also authorize this office to provide me with reasonable and proper medical care by today's standards. I acknowledge their notice of privacy practices is posted as well as available to me upon asking. I assign and request payment of medical and/or vision benefits directly to the physician for services rendered. I certify that the information provided is true and correct to the best of my knowledge. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian signature: Date:

OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient. Our office participates with most major health insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams, therefore we do not participate with vision plans. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. **A refractive examination is not a covered service by most insurance companies, including Medicare. If a refraction is performed, you will be charged for this service.**

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit.

We accept cash, checks and all major credit cards for services.

On occasion the staff at Virginia Eye Center may help you in obtaining a referral however we are not responsible for this. If a referral is not obtained and cannot be obtained before the visit you will have the choice of rescheduling the visit or paying the full fee at the time of the visit.

Because we are often unable to fill no-show appointments, or appointments cancelled with less than 24 hours' notice, you may incur a **\$50.00 cancellation fee** if either of these instances apply to you. Since other administrative requests are not covered by insurance, there will be an additional charge for services such as completion of forms (disability, DMS, etc.); and medical records requests-charge dependent on number of pages.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you. If your account is turned over to our collection agency, you agree to pay an additional fee equal to 25% of the balance forwarded to the collection agency and any additional attorney or court costs. Any check payments that do not clear the bank will be subject to a **\$35.00** returned check fee.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I have read and understand the above financial policy.

PATIENT HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name of Person(s) & Relation(s) Authorized to Discuss Medical and Financial Information:

Do you have a health care proxy in the event you are unable to make your own medical decisions)? **YES NO**
If yes, what is their name and phone number?

INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

It may be necessary for us to dilate your eyes in order to perform your eye exam.

Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes. Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. Other potential side effects include glare, blurred vision, and decreased contrast threshold which may make you more susceptible to falls. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or assistant to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You further understand and acknowledge that you have been warned of the potential risks that dilating drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

I understand that eye drops are necessary to diagnose my condition and/or examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at the office of Virginia Eye Center.

INFORMATION AND CONSENT FOR REFRACTION (CPT 92015)

Thank you for choosing Virginia Eye Center as your eye care provider. We MAY need to perform a vision test called a "refraction" (description below) to check your vision.

A refraction is a diagnostic test used to determine the patient's best ability to see. A refraction is the specific measurements of the refractive state of the eye. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This is an essential part of most ophthalmologic evaluations. This test is performed during your annual eye exam or if there has been a decrease in your vision since your last visit. This test is necessary in order for your physician to determine the best visual acuity which is needed to evaluate for possible eye diseases. The refraction may also be used as the basis for prescribing glasses or other optical devices. Based on the refraction results, there is the possibility that a prescription for glasses will not be necessary. It is also possible that refractions may need further adjustment and to exercise caution when driving until you are sure the prescription is good for you.

MOST INSURANCE COMPANIES INCLUDING MEDICARE DO NOT COVER THE REFRACTION TEST.

Our office fee for refraction, CPT 92015, is \$60. The refraction fee is collected in addition to any co-payments, coinsurance, or deductible payments at the time of service. **I accept full responsibility for the cost of this service.**

I consent to all of the above.

Patient Signature (or person authorized to sign for patient)*

Date

*My signature indicates that I understand and agree to the terms above.



Medical History Questionnaire

Name _____

Date _____

Date of Birth _____ Date of last eye exam _____ by _____

What is the reason for your visit today? _____

Who is your primary medical doctor? _____

Do you currently have any problems with your eyes?

- | | | |
|--|--|--|
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Redness | <input type="checkbox"/> Eye pain or soreness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sandy or Gritty feeling | <input type="checkbox"/> Infection of the eye or lid (blepharitis) |
| <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Itching | <input type="checkbox"/> Tired eyes |
| <input type="checkbox"/> Distorted vision (halos) | <input type="checkbox"/> Burning | <input type="checkbox"/> Drooping eyelid |
| <input type="checkbox"/> Loss of side /peripheral vision | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Excess tearing/watering | <input type="checkbox"/> Flashes |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Glare/light sensitivity | <input type="checkbox"/> None |
| <input type="checkbox"/> Mucous discharge | | |
| <input type="checkbox"/> Other: _____ | | |

Do you wear glasses or contact lenses? Glasses Contacts

Please check any chronic conditions related to your eyes:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Lazy eye | <input type="checkbox"/> Other; _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye injury/trauma | <input type="checkbox"/> None |
| <input type="checkbox"/> Detached retina | <input type="checkbox"/> Corneal problems | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Macular Degeneration | |

Please check any eye surgeries you have had:

- | | |
|--|---|
| <input type="checkbox"/> LASIK | <input type="checkbox"/> Blepharoplasty |
| <input type="checkbox"/> PRK | <input type="checkbox"/> Retinal surgery; _____ |
| <input type="checkbox"/> Cataract Surgery, left eye | <input type="checkbox"/> Other; _____ |
| <input type="checkbox"/> Cataract Surgery, right eye | <input type="checkbox"/> None |

Please check any conditions you have experienced in the last 6-12 months:

- | | |
|--|--|
| <input type="checkbox"/> Fevers <input type="checkbox"/> Chills | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Unintentional weight loss/poor appetite | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin rashes/problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Ear problems (hearing, ringing, painful earlobes) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sinus Problems – Chronic or Seasonal | <input type="checkbox"/> Diabetes; Type _____; A1C _____ BSA _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cancer; Type _____ |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Upper respiratory infection (sinus, cold) requiring antibiotics |
| | <input type="checkbox"/> None |

For women, are you pregnant? YES NO Are you nursing? YES NO

Other Medical Condition(s): _____

List any **medical surgeries** you have had: _____

PATIENT MEDICATION LIST					
I give consent for my medications to be imported from pharmacies. <input type="checkbox"/> YES <input type="checkbox"/> NO					
Medication Name	Dose	Frequency	Eye Drops Name	Dose	Frequency

Do you have any **allergies** to any medications? YES NO

If yes, please list the medications: _____

SOCIAL HISTORY

Smoking History: Current every day smoker Current some days smoker Former smoker Never smoked

Do you drink alcohol? YES NO If yes, occasional, more than 3/day

Do you drive at night? YES NO Do you drive during the day? YES NO

Do you have visual difficulty when driving? YES NO

FAMILY HISTORY **Has any member of your immediate family (blood relatives) have/had these diseases?**

Disease/Condition	yes	no	Family Member							
Lazy Eye	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Macular Degeneration	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Blindness	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Retinal Disorders	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Cataracts	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Glaucoma	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Diabetes	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Heart Disease	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Hypertension	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Stroke	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Thyroid Disease	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Arthritis	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather
Cancer Type: _____	yes	no	Mother	Father	Sister	Brother	Uncle	Aunt	Grandmother	Grandfather

Patient and/or Guardian's Signature _____

Date _____