Niloo Ziai, M.D.
Sarah A. Merrill, M.D.
Soo Y. Shin, M.D.
Ruby Parikh, M.D.
Christina Chang, M.D.
Mohib Khan, M.D.
Elaine Bourdeau, O.D.

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 $70.00.
- 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.

Sex Marital Status:
**M F** **S M W D**

First Name | MI | Last Name | Date of Birth

Street Address/City/State/Zip

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

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

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 $70.** 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.

19441 Golf Vista Plaza, Suite 320 • Lansdowne, VA 20176
Tel (703) 858-9800 • Fax (703) 858-9801

# 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?

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

Do you wear glasses or contact lenses? ☐ Glasses ☐ Contacts

Please check any chronic conditions related to your eyes:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Detached retina
- ☐ Blindness
- ☐ Lazy eye
- ☐ Eye injury/trauma
- ☐ Corneal problems
- ☐ Macular Degeneration
- ☐ Other; ______________________________
- ☐ None

Please check any eye surgeries you have had:

- ☐ LASIK
- ☐ PRK
- ☐ Cataract Surgery, left eye
- ☐ Cataract Surgery, right eye
- ☐ Blepharoplasty
- ☐ Retinal surgery;_______________________________
- ☐ Other; ________________________________________
- ☐ None

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

- ☐ Fevers ☐ Chills
- ☐ Unintentional weight loss/poor appetite
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Headache
- ☐ Ear problems (hearing, ringing, painful earlobes)
- ☐ Chronic Cough
- ☐ Sinus Problems – Chronic or Seasonal
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Heart disease
- ☐ Stomach pain
- ☐ Joint pain
- ☐ Skin rashes/problems
- ☐ Numbness or tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Diabetes; Type_____; A1C___________BSA___________
- ☐ Hypothyroidism ☐ Hyperthyroidism
- ☐ Cancer; Type__________________________________
- ☐ Night Sweats
- ☐ Upper respiratory infection (sinus, cold) requiring antibiotics
- ☐ 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. ☐YES ☐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** | | | **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<br>Type:________________ | yes | no | Mother Father Sister Brother Uncle Aunt Grandmother Grandfather |

Patient and/or Guardian's Signature Date

_________________________________________ _________________________________