Welcome to Vision Tech Optometry Center

"Modern Eye Care, Old Fashion Caring"

All information provided below will remain confidential and will be used only in accordance with HIPAA regulations.

□ Mr. □ Mrs. □ Miss □ Ms. □ Rev. □ Dr. Date: _____

_____ _____

Patient name Nickname

_____

Address City State Zip code

_____ _____ _____

Date of birth Employer/School Occupation/Grade

_____ _____ _____

Social security number or Last four Spouse/Parent name Other family members who are patients

If you are a minor, who is responsible for your account? _____ Relationship _____

Address:_____ Date of Birth_____

SS# _____ Phone _____ Work Phone _____ Employer _____

Gender: □ Female □ Male
Preferred language: □ English □ Spanish □ Other_____
Race: □ African American □ American Indian □ Arab □ Asian □ Caucasian □ Hispanic □ Indian □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Which phone number can we use to reach you? □ Home □ Work □ Cell

Home _____ Work _____ Cell _____

_____

E-mail address

_____

Primary care physician & Street address

_____ _____ _____

Emergency contact name Phone number Relationship

How will you settle your account today? □ Cash □ Check □ Credit card

INSURANCE INFORMATION

Primary medical insurance _____ Secondary medical insurance _____

Subscriber name/Date of birth _____ Subscriber name/Date of birth _____

Subscriber ID# _____ Subscriber ID# _____

NEW PATIENTS ONLY5

Who may we thank for referring you? _____

If not referred, how did you first hear about our office? □ Phone book □ Insurance list □ Saw sign/building □ Radio
□ TV □ Newspaper (which one?) _____ □ Web page (which web site?) _____
□ Other _____

Vision Tech Optometry Center
(Effective 02/08/2022)

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, **payment for visit is due at the time of the service** (either full fee if you are paying privately, or your **co-payment** if we are billing your insurance company).

If our office participates with your insurance we can submit for payment as a service to our patients; however, insurance companies do not guarantee payment and if insurance payments are not received **within 90 days** of service, **responsibility for payment switches to the guarantor**. Office staff is available to discuss potential payment issues with you. We are not participating providers with Medicaid. If your primary insurance is Medicaid, we are unable to process any insurance claims for you, if however, you have this as a secondary we will not file for you, but should this cross cover from your primary insurance to them we can apply the payment, but you are responsible for the remaining balance.

Cancellation/Reschedule Policy
We require at least 24 hours advance notice if you need to cancel or reschedule your appointment.

After One (1) No Show/Same day rescheduled appointment: You will receive a letter and a phone call informing you of the no show or same day rescheduled appointment. You will still be able to continue to receive medical services at Vision Tech Optometry Center.

After Two (2) No Shows/Same day rescheduled appointments: You will receive a second letter and phone call reminding you that this is your second no show or same day rescheduled appointment. You will still be able to receive medical services at Vision Tech Optometry Center.

After Three (3) No Shows/Same day rescheduled appointments: You will receive a third letter informing you that we are discharging you from our practice.

Please review the following:

- I understand only participating insurance may be filed for me, but I am ultimately responsible for payment of fees regardless of insurance coverage.
- I authorize the release of medical information required to process insurance claims and/or to Complete Treatment Plans/Reviews required by insurance or managed care companies.
- I authorize payment for my insurance company to be made directly to the practice.
- I understand that I am responsible for obtaining proper (pre)authorization from my insurance company. I accept responsibility for payment if authorization is not obtained.
- I understand the cancellation policy outlined above.
- I understand that mailed monthly bills are due to at the time of receipt. Any bill not paid will be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including 25% agency fees, court costs and attorney fees.

Print Name: _____

Signed: _____ Date: _____

HIPAA Policy
I have reviewed a copy of the HIPAA privacy policy and can receive a copy at my request.

Signed: _____ Date: _____

Vision Tech Optometry Center

"Modern Eye Care, Old Fashion Caring"

Patient name: _____ Today's date: _____

REASON FOR VISIT: ☐ blurry vision ☐ eye pain ☐ tearing ☐ headaches ☐ itchy eyes ☐ burning eyes ☐ gritty eyes ☐ trouble seeing at night ☐ trouble w/ glare ☐ sensitive to light ☐ floaters ☐ flashes of light ☐ other_____

PATIENT'S REVIEW OF SYMPTOMS: (Please check all that apply. If none, please check 'None')

Constitutional
☐ *None*
☐ Fatigue Syndrome
☐ Cancer _____
☐ Developmental Disability
☐ Other_____

Ear, Nose,Throat
☐ *None*
☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis
☐ Other_____

Neurological
☐ *None*
☐ Cerebral Palsy
☐ Tumor
☐ Multiple Sclerosis
☐ Epilepsy
☐ Stroke/CVA
☐ Migraine
☐ Other_____

Psychiatric
☐ *None*
☐ Depression
☐ Bipolar Disorder
☐ Anxiety Disorder
☐ Attention Deficit
☐ Other_____

Cardiovascular
☐ *None*
☐ Vascular Disease
☐ Heart Disease
☐ Congestive Heart Failure
☐ Stroke/CVA
☐ High Blood Pressure
☐ Other_____

Respiratory
☐ *None*
☐ Sleep Apnea
☐ Cigarette Smoker
☐ Chronic Obstruction
☐ Emphysema
☐ Bronchitis
☐ Asthma
☐ Other_____

Gastrointestinal
☐ *None*
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease
☐ Other_____

Genitourinary
☐ *None*
☐ Kidney Disease
☐ Prostate Disease/Cancer
☐ Pregnant
☐ Benign Prostate Hypertrophy
☐ Herpes
☐ Nursing
☐ Chlamydia
☐ Other_____

Musculoskeletal
☐ *None*
☐ Arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Ankylosing Spondylitis
☐ Osteoporosis
☐ Gout
☐ Other_____

Integumentary
☐ *None*
☐ Rosacea
☐ Eczema
☐ Herpes Simplex/Cold sores
☐ Psoriasis
☐ Herpes Zoster/Shingles
☐ Other_____

Endocrine
☐ *None*
☐ Type 1 Diabetes Mellitus
☐ Type 2 Diabetes Mellitus
☐ Hormonal Dysfunction
☐ Thyroid Dysfunction
☐ Other_____

Hematologic/Lymphatic
☐ *None*
☐ Anemia
☐ Ulcer
☐ Large volume blood loss
☐ High Cholesterol
☐ Other_____

Allergic/Immune
☐ *None*
☐ Drug allergies
☐ Sjogren's Syndrome
☐ Lupus
☐ Rheumatoid Arthritis
☐ Environmental Allergies
☐ *Other*_____

LIST ALL CURRENT MEDICATIONS: (Use back of sheet if needed)

Name _____ Strength _____
Name _____ Strength _____
Name _____ Strength _____
Name _____ Strength _____

ALLERGIES

Medication Allergies

□ No known medication allergies

List names_____

Other Allergies (environmental, food)

□ No known allergies

List allergens_____

Date of last eye exam _____

Name of last eye doctor _____

PATIENT'S PAST OCULAR HISTORY □ *Negative*

Have you ever been diagnosed or treated for the following?
(Check all that apply)

□ Dry eye
□ Nystagmus
□ Retinal detachment
□ Keratoconus
□ Injury
□ Macular degeneration
□ Cataract
□ Glaucoma suspect
□ Glaucoma
□ Strabismus (eye turn)
□ Inflammatory disorder (ex. Iritis,uveitis, scleritis)
□ Patching
□ Surgery
□ Retinal degeneration
□ Retinal hole
□ Ambloypia (lazy eye)
□ Other_____

PATIENT'S SOCIAL HISTORY

Alcohol use? □ Yes □ No □ Unknown

Amount_____

Tobacco use? □ Yes □ No □ Unknown

Preference:

□ Cigarettes
□ Cigars
□ Pipe
□ Smokes other
□ Smokeless tobacco

Amount _____

Smoking Status: (Check one)

□ Unknown if ever smoked
□ Smoker, current status unknown
□ Never smoker
□ Former smoker
□ Current some day smoker
□ Current every day smoker
□ Heavy tobacco smoker
□ Light tobacco smoker

*Immediate is Parents, Siblings and Children

List Hobbies: _____

IMMEDIATE FAMILY MEDICAL HISTORY □ *Negative*

□ Thyroid Relationship_____
□ Cancer _____ Relationship_____
□ Diabetes Relationship_____
□ Hypertension Relationship_____

Circle which type if known: Hyper or Hypo

Circle which type if known: Type I or Type II

IMMEDIATE FAMILY OCULAR HISTORY □ *Negative*

□ Glaucoma Relationship _____
□ Cataracts Relationship _____
□ Macular degeneration Relationship _____
□ Glaucoma suspect Relationship _____
□ Severe nearsightedness Relationship _____
□ Amblyopia Relationship _____
□ Severe farsightedness Relationship _____
□ Strabismus (eye turn) Relationship _____
□ Retinal detachment Relationship _____
□ Dry Eye Relationship _____
□ Nystagmus Relationship _____

Do you wear contacts? _____

If so, which brand? _____

Which solution do you use? _____

How often do you get a new pair? _____

VISION TECH OPTOMETRY CENTER, INC.

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Information)
   I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. Persons to Whom Disclosure May Be Made
   Provider may disclose my PHI to the following persons:

   Name — Relationship, if any **and telephone numbers**

   _____ _____

   _____ _____

   _____ _____

3. Purpose of Disclosure
   The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. Expiration of Authorization
   This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer of Vision Tech Optometry Center.

5. Conditioning of Treatment
   Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. Redisclosure by Recipient
   I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer by protected by federal or state law.

7. Acknowledgment of Reading and Agreement
   I have read and understand this authorization.

_____
Print Patient Name (also print Representative Name if applicable)

_____ _____
Patient or Representative Signature — Date

If a representative signs, state the representative's authority: _____

Vision Tech Optometry Center, Inc.

Dr. Jennifer E. Davis • Dr. Mark D. Rodammer

221 Osage Ln. Suite A • Waynesboro VA 22980 • PHONE: 540-932-2020 • FAX: 540-943-6170

Release of Health Information from Your Primary Care Provider

Patient Name: _____ **Date of Birth:** _____

☐ All information including Patient History, Examinations, Diagnoses and Treatments

☑ Only the information specified below (Ex. Specific dates of service, type of service)

Medication and Allergy List, Please

Purpose of Release: ☐ **Transfer of Care** ☐ **Other:** _____

I Hereby Authorize:

_____
Name of Physician, Organization or Person

_____
Mailing Address

_____
City, State, Zip Code

_____
Phone/Fax Number

To Release To:

Vision Tech Optometry Center, Inc.
Jennifer E. Davis, OD
Mark D. Rodammer, OD
221 Osage Ln., Suite A
Waynesboro, VA 22980

PHONE: 540-932-2020
FAX: 540-943-6170

Please accept facsimile signatures as the original:

_____ _____
Patient Signature -or- Responsible Party Print Name & Signature *Date*

_____ _____
Witness Signature *Date*

This release will expire on:

_____

*If no expiration date is given, release will terminate 1 year from date signed.

Privacy Rights Regarding This Authorization:

1. **You do not have to sign this release to receive treatment at Vision Tech Optometry Center, Inc. In fact, you have the right to refuse to sign this release.**
2. **When your information is used or disclosed pursuant to this release, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.**
3. **You have the right to revoke this release. To do so, you must indicate your wish in writing, submitted to the Privacy Officer at Vision Tech Optometry Center, Inc. 221 Osage Ln., Ste. A, Waynesboro, VA 22980. We will not be able to retrieve your information if we have already disclosed it.**
4. **Vision Tech Optometry Center, Inc. will not receive payment or other remuneration from a third party in exchange for using or disclosing your information except to cover the cost of copying, mailing, etc.**
5. **Your information may be released in paper or electronic form.**