PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State ZIP

Marital Status _____ Race _____

Preferred language _____ Ethnicity _____

Sex: ☐ M ☐ F Age _____ Birthdate _____

SSN _____

Height _____ Weight _____

Home Phone # _____

Cell Phone # _____

Email Address _____

Patient Occupation _____

Patient Employer _____

Employer Telephone _____

Spouse _____

Whom may we thank for referring you? _____

Emergency contact/number _____

Family Doctor _____ Last visit _____

Last Eye Doctor _____ Last exam _____

INSURANCE

Primary Insurance _____

Secondary Insurance _____

Vision Insurance _____

Name of Insured _____

SSN ___-___-___ DOB ___/___/___

If other than insured…

Guarantor name _____

Address _____

Phone # ( ) _____-_____

SSN ___-___-___ DOB ___/___/___

SCREENING. IMAGING & DILATION

Digital retinal imaging is used to track or diagnose abnormal eye conditions. Our fee for this service is $35.
☐ **ACCEPT** ☐ **DECLINE** ☐ **SPEAK WITH DR.**

Dilation allows a more thorough examination of the eye and is recommend for new patients and diabetic patients.
☐ **ACCEPT** ☐ **DECLINE** ☐ **SPEAK WITH DR.**

MPOD Screening determines pigment density in your macula. Our fee for this service is $15.
☐ **ACCEPT** ☐ **DECLINE** ☐ **SPEAK WITH DR.**

Are you interested in contacts? ☐ No ☐Yes

Do you wear contact lenses? ☐ No ☐Yes If yes, **Soft** or **Rigid**. **Are they comfortable?** ☐ Yes or ☐ No

Do you wear glasses? ☐ No ☐Yes If yes, how often? ☐ **TV** ☐ **Reading** ☐ **Driving**

Do you drive? ☐ No ☐Yes If yes, visual difficulty when driving? Please describe: _____

_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Do you use any of the following: Tobacco ☐ No **If no**, ☐ Former smoker ☐ If Yes_____how long / # of packs___

Illegal Drugs ☐ No ☐Yes **Alcohol** ☐ No ☐ Yes **If yes** ☐ **Social** ☐ **1-2 drinks** ☐ **Above average**

Please list all current Medications and associated conditions

_____

_____

_____

_____

_____

_____

Please list all Allergies including Medication Allergies:

_____

_____

_____

Preferred Pharmacy: _____ Location: _____ Phone #: _____

Review of Systems: We are required by Medicare and Other Insurance Companies to ask the following questions. Do you currently or have you ever had any problems in the following areas:

	CURRENT	PAST	NO
CONSTITUTIONAL			
Fever, Weight loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Cataract	☐	☐	☐
Chalazion or Stye	☐	☐	☐
Chronic Infection (Eye/Lid)	☐	☐	☐
Crossed Eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Injury/Trauma/Surgery	☐	☐	☐
Lazy Eye	☐	☐	☐
Macular Degeneration/Retina	☐	☐	☐
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes	☐	☐	☐
Floaters in Vision	☐	☐	☐
Foreign Body/Gritty/Sandy	☐	☐	☐
Glare	☐	☐	☐
Halos/Distorted Vision	☐	☐	☐
Itching	☐	☐	☐
Light Sensitivity	☐	☐	☐
Loss of Vision/Side Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Tearing/Watering	☐	☐	☐
Tired Eyes	☐	☐	☐
Twitching Eyelid	☐	☐	☐
Other: Explain_____			

	CURRENT	PAST	NO
EARS / NOSE / MOUTH / THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Stroke	☐	☐	☐
GASTROINTESTINAL			
Crohn's Disease	☐	☐	☐
Celiac's Disease	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Arthritis (Rheumatoid)	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
ENDOCRINE / LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Diabetes (Type 1/Type 2)	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PREGNANT / NURSING	☐	☐	☐
PSYCHIATRIC/DEPRESSION	☐	☐	☐
OTHER Explain_____			

Please list all major injuries, surgeries, and/or hospitalizations_____

_____

_____

Please note family history and linked family member (parents, grandparents, siblings,etc) living or deceased

Blindness	_____	Retinal Disease	_____	High Blood Pressure	_____
Cataract	_____	Arthritis	_____	Kidney Disease	_____
Crossed Eyes/Lazy Eye	_____	Cancer	_____	Lupus	_____
Glaucoma	_____	Diabetes	_____	Thyroid Disease	_____
Macular Degeneration	_____	Heart Disease	_____	Other explain	_____

_____ _____

Patient's Signature **Date** **Doctor's Signature** **Date**

PATIENT PRIVACY CONSENT FORM

I, _____, give my expressed permission to share my health information with the following:

1. _____ 3._____

2. _____ 4. _____

Note: Under NO circumstances will we provide anyone not listed above ANY information from New River Eye Care without your consent. *You may add or remove names at any time.*

I wish to be called at [_] Home, [_] Cell, [_] Other (check **all** that apply) regarding my care/follow up.

The best phone numbers to reach me are:
Home_____,Cell_____,Other_____

[_] I DO [_] I DO NOT : give my permission to leave relevant medical information on my voice mail.

[_] I DO [_] I DO NOT : want relevant information shared with person who may answer the phone.

[_] I have reviewed the New River Eye Care Notice of Privacy Practices and understand that I may request a copy at the front desk or may review the policy at www.mountaineyes.com

Policies and Procedures

APPOINTMENTS AND REFERRALS: There will be a $25 rescheduling fee for the second missed appointment without a 24 hour notice. I am also aware that after 3 missed appointments I may also be released as a patient for failure to keep my health assessment updated. I acknowledge that if the medical staff of New River Eye Care refers me to another physician or specialist for treatment of a specific health issue, I must comply with this appointment. Failure to do so may result in being released as a patient.

SELF PAY/NON PARTICIPATING INSURANCE POLICY: New River Eye Care does not participate with all insurance companies. It is your responsibility as a patient/guardian of a patient to know which physicians are participating providers with your medical insurance policy. You can contact your insurance company for that information. If your insurance requires a referral, it is your responsibility to ensure that we have received that referral prior to your scheduled appointment. If we have not received your referral prior to your appointment, you will be responsible for the full amount of any charges not covered by your insurance.

Examples of insurances that we **do not** participate with include, but are not limited to: Block Vision, Davis, NVA, Spectera/Optum Health, West Virginia Medicaid, and West Virginia Chips. As non-participating physicians we do not have a contract with these particular insurance companies. This

means that your insurance company may not pay for any medical charges or may pay at a reduced rate for services that are rendered at New River Eye Care. Payment, in full, is due at the date of service.

With very few exceptions, we will file your medical insurance claim on your behalf with your current insurance company. If your insurance company pays any portion of your claim, even though we are a non-participating provider, you will be reimbursed any monies due to you when our billing department receives that insurance payment.

By signing below, I understand that if New River Eye Care is a non-participating provider with my particular medical insurance, or I am a self-pay patient; I am responsible for all or a percentage of any services rendered by New River Eye Care.

PAST DUE ACCOUNTS: Payments not received upon the date of medical services or statement date, will be considered delinquent, and interest at a rate of 20% will accrue until the balance is resolved. You further agree to be financially responsible for any collection cost associated with the balance recovery due our office, i.e. collection agency fees; attorney fees; court cost; and/or certified mailing cost. Any personal check declined by your banking institute will result in a $25 charge, plus any bank fee incurred. Should civil litigation be required to necessitate the collection of any delinquent amounts or to resolve any disputes, you agree to the following court venue: Giles County, VA. By providing your cell phone as a means of contact and communication, you hereby authorize our office and our business associates to also communicate with you at this number. This would include, but not limit to, communication from our collection agency, and/or collection attorney. You understand that you may incur an expense during cell phone communication.

MEDICARE AND PRIVATE INSURANCE REGULATION CHANGES: When you are seen for a regularly scheduled eye exam and need to have special testing or procedures done, it may be done in a separate appointment on a separate date. Testing and procedures may have additional charges depending on your insurance coverage plan.

FRAME AND SPECTACLE LENS POLICY: All glasses are custom made and therefore, changes, cancellations and/or cash refunds are not permitted. At the doctor's discretion, patients who are not satisfied with their vision in their new glasses will have the prescription adjusted at no additional cost within 60 days. For patients who are not satisfied with their vision through new glasses that were purchased elsewhere, there will be a $50 fee to see the doctor. Please ask the opticians for details regarding warranty information as every custom order is different.

CONTACT LENS POLICY: Contact lens exams include follow up care for 60 days for all contact related visits. After 60 days, there will be a $20 fee per office visit. Rigid gas permeable contact lenses must be returned within 60 days from the date they were ordered if an adjustment is necessary. Opened boxes of soft contact lenses cannot be returned.

BY SIGNING BELOW, I ACKNOWLEDGE AND CONSENT TO THE ABOVE POLICIES AND PROCEDURES OF NEW RIVER EYE CARE:

Patient Signature _____ Date_____

Patient Printed Name _____