BLACKSBURG EYE ASSOCIATES

Date:_____

Name:_____ Preferred Name: _____ Last 4 SSN#_____

Address:_____City:_____

State:_____ Zip:_____ Home#:_____

Work#:_____ Cell#:_____ e-mail:_____

Date of Birth:_____ Birth Gender (sex):_____ Status: ○ **S**ingle ○ **M**arried ○ **D**ivorced ○ **W**idow(er)

Race:_____ Ethnicity: ○ Hispanic or Latino ○ Non Hispanic or Latino

Work (or School):_____ Occupation (or Grade if in school):_____

Your Primary Care Physician (PCP):_____

Method of Communication: (Write a "Y" for yes and "N" for no by each option)

_____ Email _____ Phone _____ Text Message (Usage and data rates may apply)

The above information is correct to the best of my knowledge.

Signature:_____ Date:_____

Medical and Ocular History

Patient's Name_____Date of birth_____

Do you have any allergies to medications? If yes, please list_____

List all medications you currently take (including eye drops, oral contraceptives, aspirin, vitamins and supplements)

_____

_____

_____

Personal Medical History

Do you currently have or have ever had any of the following conditions? Check those that apply.

General Health
- ❒ Currently Pregnant or Nursing
- ❒ Developmental Disability
- ❒ Cancer - Type_____
- ❒ Tobacco Use
  Type_____Amount_____
- ❒ Alcohol Use
  Type_____Amount_____
- ❒ Drug Use

Allergic/Immunologic
- ❒ Environmental Allergies
- ❒ Chronic Sinus Congestion/Cough
- ❒ Lupus / Rheumatoid Arthritis

Cardiovascular
- ❒ Hypertension/High Blood Pressure
- ❒ Stroke
- ❒ Heart Disease
- ❒ High Cholesterol

Endocrine
- ❒ Diabetes
- ❒ Hypothyroid / Hyperthyroid

Gastrointestinal
- ❒ Crohns / Colitis / Ulcer
- ❒ Other_____

Respiratory
- ❒ Asthma
- ❒ Emphysema
- ❒ Chronic Bronchitis

Eyes
- ❒ Retinal Detachment/Disease
- ❒ Glaucoma/Optic nerve disorder
- ❒ Cataracts
- ❒ Macular Degeneration
- ❒ Lazy/Crossed Eye
- ❒ Corneal Disease
- ❒ Eye Injury
- ❒ Eye Allergies
- ❒ Prism In glasses
- ❒ Double Vision
- ❒ Dry Eyes

Dermatologic
- ❒ Eczema
- ❒ Rosacea
- ❒ Psoriasis

Musculoskeletal
- ❒ Muscular Dystrophy
- ❒ Osteoarthritis
- ❒ Ankylosing Spondylitis
- ❒ Fibromyalgia

Hematologic/Lymphatic
- ❒ Bleeding Problems
- ❒ Leukemia
- ❒ Anemia

Genitourinary
- ❒ Kidney or Bladder Disease
- ❒ Other_____

Psychiatric
- ❒ Depression
- ❒ Anxiety
- ❒ Other _____

Neurological
- ❒ Multiple Sclerosis
- ❒ Seizures
- ❒ Head Trauma
- ❒ Headaches/Migraines

Infectious Disease
- ❒ AIDS/HIV
- ❒ Hepatitis
- ❒ Tuberculosis
- ❒ STDs_____

Other Health Conditions
- ❒ _____

Have you had any major ocular injuries or surgeries? Please list them.

_____

_____

Family History

Does any family member (parents, grandparents, siblings, or children) currently have or had any of the following conditions? Please write the relationship to you.

- ❒ Blindness _____
- ❒ Cataract_____
- ❒ Retinal Detachment_____
- ❒ Glaucoma_____
- ❒ Macular Degeneration_____
- ❒ High Blood Pressure_____
- ❒ Diabetes_____
- ❒ Thyroid Disease_____
- ❒ Cancer_____
- ❒ Heart Disease_____

Patient's Signature_____Date _____

HISTORY REVIEW For Office Use only

Provider/Tech_____ Date_____

BLACKSBURG EYE ASSOCIATES

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible care involves a mutual understanding between the patient and provider. Should you have any questions about the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for the services rendered to you is your responsibility.

- I authorize Blacksburg Eye Associates to bill my insurance companies for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- I may request services to not be billed to insurance, and that I would be solely responsible for payment.
- I may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, my right to access is suspended until the clinical trial is completed.
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- By signing this consent form you are agreeing that your provider at Blacksburg Eye Associates may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Blacksburg Eye Associates to enroll me in this ePrescribe Program
- I understand there may be medical findings during the course of my exam. I understand it is a violation of Blacksburg Eye Associate's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles as per my agreement with my insurance company. I also understand that Blacksburg Eye Associates will not neglect medical findings in order to bill my vision wellness plan, as that would put Blacksburg Eye Associates in direct conflict with its ethical obligations to the Virginia Board of Optometry.
- I understand there is a $50 fee for all returned checks.

I understand and agree to all of the statements made herein and that this is a binding agreement.

Signature:_____ Date:_____

Printed Name:_____ Relationship:_____

NOTICE OF PRIVACY PRACTICES / HIPAA AUTHORIZATION

By signing below you attest that you have been informed of / offered this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. I am free to refer to this policy at any time. These policies are subject to change or modification as legislation changes.

I give permission to Blacksburg Eye Associates to discuss or release health information identifying me to my insurance companies, pharmacies, referring/consulting physicians and the following authorized people / entities: (names:)_____

Signature:_____ Date:_____

BLACKSBURG EYE ASSOCIATES

(please print)

Student / Dependent Additional Information

There are a few things you will need to do prior to your appointment to make sure you are seen on time and that you can fully use your insurance benefits. Feel free to email any questions to info@blacksburgeye.com.

1. Find out if you have routine vision coverage and find out who it is through. You can call the toll-free number on the back of your insurance card and ask. This process normally takes less than five minutes. For example, many (but not all) Anthem Blue Cross Blue Shield plans have EyeMed for their vision coverage, but some may have VSP.

2. If your insurance is through your parents/guardians there are a few important pieces of information we will need for you to use your benefits. Even if we have a copy of the card we will likely need their date of birth, home address, home phone and SSN. Payment (including all necessary insurance information) is required at the time of service and if you do not have this information readily available we can take payment and give you an insurance receipt that you may submit to the insurance company for reimbursement.

3. Come into the office early so we can finish any paperwork and address any concerns before your scheduled exam time. Don't forget to bring your card(s) with you.

Medical Insurance Carrier (Anthem, Aetna, Southern Health, etc): _____

Does your health insurance have a vision-care rider? (You may have to call to verify)

Name of vision carrier (VSP, EyeMed, etc): _____

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Holder's Home Phone Number:_____ Policy Holder's SSN:_____

Policy Holders Home Address: _____

Don't forget to bring the insurance cards with you! Without all of the required information we may not be able to check benefits at the time of the visit.

Up your game with cutting-edge eye care - it's not your father's eye exam.

Blacksburg Eye Associates put together a technology package because we strongly believe that the earlier that problems are detected the easier they are to manage. This leads to better outcomes - keeping you seeing and looking your best for years to come.

Our technology package includes the Optos Daytona and iWellness exam from Optovue. With good images we **may be able to skip the strong dilating drops** for some patients (some eye drops may still be needed).

These tests are not a replacement for a dilated exam – they are a great supplement to it. We will still need to dilate many at-risk patients including patients with retinal disease and patients with **high prescriptions**. It is recommended for these patients to have both imaging and dilation.

To provide the highest level of care, our doctors **strongly recommend** that all of our patients have these tests performed **annually**. It is especially important for people who have any one or more of the following:

1. Floaters, spots, or flashes of light in vision
2. Family (or personal) history of hypertension, high cholesterol, or diabetes
3. Family (or personal) history of glaucoma
4. Family (or personal) history of macular degeneration or retinal disorders
5. Change in history of headaches
6. Recent changes in vision
7. Vision not correctable to 20/20 with glasses or contact lenses

These screening studies typically cannot be billed to your insurance and have a **fee of only $45.00.**

Our doctors think the Optomap image is so valuable that we provide it free of charge for children 16 years old and under. Because of the nature of children's eyes and how the visual system works, a dilation will still be required.

Please check the appropriate line below and sign at the bottom.

◯ **I ELECT** to have the procedure performed

◯ **I decline** or have questions about these tests

_____ _____

Signature (type initials for digital signature) Date