Visionary Eye Doctors™
Advanced technology with a loving touch

Acct #: _____

NEW PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Full Name: First	Middle Int.	Last	Nickname:

Address:	Apt No.	City	State	Zip

Email	Primary phone number	Work number	Date of Birth

EMERGENCY CONTACT

Person to Notify for emergency	Relationship	Home Phone	Cell Phone

PCP INFORMATION

Primary Care Physician Name	Phone No.	Fax No.

Additional Information:

Thank you for filling in the information above. Please continue with our office policies, when forms are completed please return to the front desk receptionist. If you have any questions before completing, please ask one of the receptionists, and we will gladly assist you.

Visionary Eye Doctors Patient Agreement, Office & Financial Policies

Thank you for choosing Visionary Eye Doctors. We are committed to providing you with the best eye care possible. In order to accomplish this, we need your assistance in understanding our practice policies.

1. **Cancellations and Late Arrivals:**

If you must cancel your appointment, we ask that you notify us within 48 hours of your appointment so that we may offer that time to another patient. Failure to notify us at least 24 hours in advance may result in a $55.00 missed appointment fee. Missed appointments are subject to a prepayment charge **prior to rescheduling** and cannot be filed to insurance. If you are more than 30 minutes late to your scheduled appointment, we will make every effort to accommodate you, however, we may have no choice but to reschedule your appointment. We thank you for your understanding.

Patient Initials _____

2. **Insurance & Patient Responsibility for the Bill**

Visionary Eye Doctors contracts with or accepts most insurance plans. While we strive to educate our patients on their insurance benefits, **it is THE PATIENTS RESPONSIBILITY to be aware of their insurance benefits including deductible, office visit copays and referrals required by insurance**.

All patients are financially responsible for the timely payment of all charges incurred. For those patients with insurances accepted by our doctors, Visionary Eye Doctors will submit the bill to the patient's insurance company first for payment. All services not covered by your insurance will be your responsibility and billed to you in accordance with your specific insurance policy.

Payment is due at the time of your visit for any co-payment, deductible or coinsurance amount.
Unless other payment arrangements have been made with our billing department, we require patients to pay their co-pay, deductible and all out of pocket expenses BEFORE leaving the office.

Any and all outstanding balances must be paid, or payment arrangements made and in good standing, at the time of check-in. You must pay outstanding balances within 90 days may result in the practice forwarding your account to a collection agency of our choosing and may result in additional fees being charged to your account.

Patient Initials _____

3. **Referrals**

Referrals must be presented at time of check-in before proceeding with the visit. It is the patient's responsibility to ensure they have a valid referral for their visit, and to know how many visits are allowed, and expiration date of their referral. We cannot bill your insurance without a valid referral, and you may be asked to reschedule your appointment. **If you choose to be seen without a valid referral, payment for services rendered at your visit are due at the time of checkout**.

Patient Initials _____

4. **Non-Covered Services & Point of Service Collection**

Payment for non-covered services, such as refractions or contact lens fittings, is due at the time services are rendered. We accept, cash, checks, and major credit cards for your convenience. Any outstanding balances are also due at the time of service.
If we suspect that a service may not be covered by your insurance company, for example many dry eye procedures are seen as experimental and are therefore not covered by most insurance plans, we ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you accept financial

responsibility. This applies to all services your doctor feels are needed in your treatment plan, but that your insurance company may deem non-covered, experimental and / or cosmetic in nature.

Please Note: Payment for all cataract surgery, refractive surgery (LASIK, PRK), and most elective procedures is due 2 weeks prior to services being rendered. Surgical procedures cancelled within one week of surgery will be assessed a cancellation fee based on proximity to surgery date.

Patient Initials _____

5. **Refraction and Additional Fee**

The refraction is part of your eye examination during which the doctor or technician offers you a series of lens choices to choose from until you reach your best corrected vision. This is to assess the overall health of your eyes and helps the doctor determine if your vision has changed. If you are experiencing blurred vision or decreased visual acuity as measured by the eye chart, a refraction will help determine whether the difficulty is the result of a medical problem, a need for an updated glasses prescription, or a new contact lens prescription.

Medicare and other forms of insurance do not consider a refraction to be part of a comprehensive eye exam. **Medicare will not pay for this service but requires eye doctors to charge separately for it and has enforced this policy since 2007.** As many private insurance carriers adopt the policies of Medicare, **your secondary coverage will not cover a refraction if Medicare does not**. If a refraction is a necessary part of your exam today, we will perform it and you will be **charged a fee of $67.00** today at check-out.

Patient Initials _____

6. **Vision Insurance vs. Medical Insurance**

When scheduling an appointment with Visionary Eye Doctors, you are usually coming in for one of two reasons: your annual routine visits or you are having a medical eye problem. Please let us know what your primary concern is for your visit so we can help you maximize your benefits and obtain the correct insurance information.
Please note all copays, deductibles & co-insurance fees are due at the time of your visit.

a. **Vision Plans**

Vision plans are for routine visits where you do not have any medical issues, problems, or diagnoses. We participate with VSP, EyeMed, Davis Vision, March Vision, Avesis, Superior Vision and National Vision Administrators (NVA) Vision plans. **Please inform us if you have a vision plan and the name of the plan BEFORE your exam.**

Many vision plans **do not cover** annual contact lens evaluations or contact lens fittings for first time wearers or established wearers that need to switch to a new brand.

b. **Medical Insurance Plans**

Medical insurance is used if you have an eye disease or medical condition is present that causes eye problems.

Unfortunately, due to insurance company policies you cannot use your vision and medical insurance for a joint exam on the same day.

Below are two possible alternatives:

1. We can schedule your **medical and vision exams on separate days** or bring you back for a separate visit from your annual wellness exam to treat any medical concerns. Parts of your exam may be repeated due to minimum visit requirements by law.
2. If you need to schedule your **medical and vision visits on the same day**, we will bill your medical insurance for the medical exam portion, and you will be charged the additional flat rate fee of $67.00 for a refraction.

Patient Initials _____

7. Pediatric Patients (If applicable)

A minor child needs an agreement signed by a parent or guardian. We require a parent or guardian accompany a minor under the age of 18 to all appointments. An ID of the parent and/or guardian will be needed.

Parent or Guardian Initials _____

8. Authorization for use of Patient Contact Methods

We might be unable to contact patients directly during normal business hours. On these occasions, our office contacts patients and leaves messages through the communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, cell phone, or email account includes, but is not limited to test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

Please check ONE box below:

( ) Yes, I agree **( ) No**, I do not agree

Patient Initials _____

9. Media Release Consent

Please be advised that throughout your appointment in our office, you may be photographed, videotaped, or possible interviewed. With your consent, any photo, video, or interview may be released for the use of media such as newsletters, emails, brochures, practice website, and/or any social media platforms.

Please check ONE box below:

( ) Yes, I consent **( ) No**, I DO NOT consent

Patient Initials _____

10. Authorization to Participate in Research:

Our office conducts academic research to improve our medical techniques and further contribute to the field ophthalmology. Information used in our clinic, such as photographs, videos, diagnoses, measurements & other relevant information regarding your eyes and general health may be included in our research efforts. Your identity will always be protected. In compliance with HIPAA regulations, your personal information will not be included in our research. Your medical care will not be affected by choosing not to participate in our research efforts.

Please check ONE box below:

( ) Yes, I consent **( ) No**, I DO NOT consent

Patient Initials _____

I have read and understood the patient agreement, office and financial policies of Visionary Eye Doctors as outlined above.

_____ _____

Print Name of Patient/Responsible Party **Date**

_____ _____

Signature of Patient/Responsible Party **Date**

PRIVACY ACT NOTICE FOR PATIENT

Use and Disclosure of Protected Health Information

Please note, our *Notice of Privacy Practices* policy, is available at the front desk, Visionary Ophthalmology, doing business as Visionary Eye Doctors, and also online at our website, www.voeyedr.com. This *Notice of Privacy Practices* provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated.

Acknowledgement & Consent Form for Use and Disclosure of Information

Copies of our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you, and is compliant with the requirements of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA*). Our *Notice of Privacy Practices* states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date in our office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. By signing below, I acknowledge receipt of the *Notice of Privacy Practices* and give my full consent to Visionary Ophthalmology, doing business as Visionary Eye Doctors, to the use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent. If you have any questions please call us at **301-896-0890.**

_____

Patient/Responsible Party Signature **Date**

_____

Patient/Responsible Party Printed **Date**

Personal Representative, Family or Other Entities Authorized Access to Protected Health Information to be Used and/or Disclosed

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

_____

Name of Authorized Person or Entity **Relationship** **Phone number**

_____

Name of Authorized Person or Entity **Relationship** **Phone number**

COVID-19 INFORMED CONSENT TO TREAT

I understand that Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices; involving my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic.

To proceed with receiving care, I confirm and understand the following (Initial in all eight places provided)	**Initial below**
I understand that I am opting for an elective treatment that may not be urgent or medically necessary and that I have the option to defer my treatment to a later date.	
I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: **Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat, Loss of Taste or Smell**	
I confirm that I or no one around me has been diagnosed with COVID-19 in the last 14 days.	
I am informed that the staff have implemented preventative measures intended to reduce the spread of COVID-19. Due to the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I give my permission to proceed with my appointment.	
I have been offered a copy of this consent form.	

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT RECOMMENED. THIS CONSENT COVERS THE ENTIRE COURSE OF CARE IN THIS OFFICE FOR MY PRESENT AND FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

PATIENT SIGNATURE _____ **PARENT/ GUARDIAN SIGNATURE** _____

NAME _____ **NAME** _____

DATE _____ **DATE** _____