Visionary Eye Doctors
Advanced technology with a loving touch

NEW PATIENT REGISTRATION FORM

Acct #: ______________

PATIENT INFORMATION

Last Name________________________________ **First Name**______________________________**MI** __________

Nickname______________________**Date of Birth**_______________________ **SS#** ________________________

Address____ Apt #: ______________

City____________________________**ST**__________**ZIP**__________ **Email**_______________________________

Home Phone # _________________ **Work Phone #** ___________________**Cell Phone #** ____________________

Emergency Contact _________________________**Relationship**_________________ **Phone #** ________________

Birth Sex:

☐**Male** ☐**Female** ☐**Unknown**

Preferred Pronouns:

☐**She/Her/Hers** ☐**He/Him/His**

☐**They/Them/Theirs** ☐**Prefer not to answer**

Gender Identity:

☐**Male** ☐**Female** ☐**Other**______________

☐**Male-to-Female (MTF)/Transgender Female**

☐**Female-to-Male (FTM)/Transgender Male**

☐**Genderqueer, neither exclusively**

PCP INFORMATION

Primary Care Physician Name______________________ **Phone #** __________________**Fax #** ________________

INSURANCE INFORMATION

Primary Insurance Name ____________________________ **Policy #** _______________ **Group #** ______________

Subscriber Name______________________ **Subscriber DOB**_______________ **Subscriber SS#** _______________

Secondary Insurance Name ___________________________**Policy #** _______________ **Group #** ______________

Subscriber Name______________________ **Subscriber DOB**_______________ **Subscriber SS#** _______________

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. If you are more than 30 minutes late to your scheduled appointment, we may have no choice but to reschedule your appointment.

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

   Visionary Eye Doctors contracts with or accepts most insurance plans. All services not covered by your insurance will be your responsibility and billed to you. **It is THE PATIENT'S RESPONSIBILITY to be aware of their insurance benefits including deductible, office visit copays, and referrals required by insurance**.

<u>Payment is due at the time of your visit</u> for any balance, co-payment, deductible, or coinsurance amount. We accept, cash, checks, and major credit cards for your convenience. Outstanding balances must be paid within 90 days; after 90 days your account may be sent to collection agency of our choosing. Additional fees may be applied.

Medicare and other forms of insurance do not consider a refraction to be part of a comprehensive eye exam. This part of the examination determines prescription for glasses. 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.

3. Vision Insurance vs. Medical Insurance

Visionary Eye doctors provides Medical Eye Exams and Vision Eye Exams.

a. **Vision Plans -** routine with no medical issues, problems, or diagnoses
b. **Medical Insurance Plans -** 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.

<u>Below are two possible alternatives:</u>

1. We can schedule your **<u>medical and vision exams on separate days</u>**. Parts of your exam may be repeated due to minimum visit requirements by law.
2. If you need to schedule your **<u>medical and vision visits on the same day</u>**, we will bill your medical insurance for the medical exam portion, and you will be charged the fee of $67.00 for a refraction.

4. 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.

5. Authorization for use of Patient Contact Methods

Protected Healthcare Information may possibly be disclosed 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. **Under HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication.**

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

6. Consent for Health Information Exchange (HIE)

Health Information Exchange (HIE) is the secure electronic sending and receiving of clinical health information that can be shared amongst providers participating in an HIE network. Visionary Ophthalmology (VED) cannot share your information with your other providers through an HIE network if you opt out. Your care at VED will not be affected if you decide to opt out.

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

7. Authorization to Record/Media Release Consent

Please be advised that throughout your appointment in our office, you may be photographed, interviewed, and recorded by both video and audio. These recordings may be used for customer service, training, marketing or for the use of media such as newsletters, emails, brochures, practice website, and/or any social media platforms. By signing this form, you consent to audio and video recordings while in the office.

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

8. Covid-19 Consent

I confirm that I or no one around me has been diagnosed with COVID-19 in the last 7 days, I am not experiencing any COVID-19 related systems, I confirm and give consent to receive care during this global pandemic.

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

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 online at our website, www.voeyedr.com.

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.**

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.

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

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

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

______________________________________ ________________________

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

______________________________________ ________________________

Signature of Patient/Responsible Party **Date**