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

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

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

☐Genderqueer, neither exclusively

☐Other_____

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**.

Payment is due at the time of your visit 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.

Below are two possible alternatives:

a. We can schedule your **medical and vision exams on separate days**. Parts of your exam may be repeated due to minimum visit requirements by law.

b. 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 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.

The following three questions address the manner in which the practice may contact you about sensitive information that may be classified as protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Please review the following information and selections carefully.

5. Permissible Methods of Contact by Practice

From time to time, the practice may need to contact you regarding appointments, scheduling, test results, prescription or pharmacy information, and similar items. HIPAA regulations generally permit us to contact you via first-class mail, phone call or encrypted electronic messaging system. HIPAA requires that we implement safeguards for protecting any protected health information that is transmitted electronically. However, certain forms of communications are not secure and, despite the safeguards we may put into place for the practice, may be vulnerable to unauthorized access or disclosure. For these forms of communication, we are required to obtain your consent prior to using them to contact you.

You may consent for the practice to contact you through additional methods of electronic communication. Please understand that transmission of data through unencrypted electronic means (e.g., e-mail or text message) is subject to certain security vulnerabilities. It is therefore impossible to safeguard the data completely against access by third-parties. The practice does not assume any liability for unauthorized access to, use of or disclosure of your health information as a result of these security vulnerabilities.

Authorization for Additional Methods of Contact

If you would like to authorize the practice to contact you through any additional electronic means, please indicate by checking the respective box(es) below. You reserve the right to revoke this consent at any time by notifying the practice.
( ) Email ( ) Text Message ( ) VED Online Patient Portal

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 Photograph, Interview and Record

From time to time, the practice may wish to photograph, interview and/or record patients (by video and/or audio). These photographs, interviews and recordings may be used for educational purposes (including staff training), medical publications, marketing, and media (e.g., newsletters, e-mails, brochures, practice website and social media platforms). In the event that these photographs or recordings contain identifying information about you (i.e. your face, voice, or other identifiable feature), we must obtain your consent before taking them.

Please acknowledge below if you consent to the practice photographing, interviewing and/or recording you. If you authorize the practice to use the audio-visual aids selected below, if any (e.g., staff training). You reserve the right to revoke this consent at any time by notifying the practice. Note, however, that you can only revoke the practice's future use of the photographs and recordings, and not uses that have already occurred (e.g., publication in a medical article).

( ) Yes, I consent to being photographed, interviewed, and/or recorded (by video and/or audio).

( ) No, I do not consent to being photographed, interviewed, and/or recorded (by video and/or audio).

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.

_____

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

_____

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**