Revised 3/3/2010

Pt. Chart #_____________

BEACH EYE CARE
Neatrour Eye Institute

Office # 757-425-5550

G. Peyton Neatrour, MD
Vivek Jain, MD
Teresa Shenouda, MD

Mark Lipton, OD
David Tang, OD
Jeffrey Dunn, OD

1201 First Colonial Rd.
Virginia Beach, VA. 23454

1209 Independence Blvd. Suite 105
Virginia Beach, VA. 23455

2173 Upton Dr. Suite # 601
Virginia Beach, VA. 23454

Patient Information

PLEASE PRINT

(Last) (First) (M.I.)

Patient: ____

Name you prefer to be called____________________

Address:____

____

City State Zip

Sex: M F Age _____ DOB ____/____/_____

Single Married Separated Divorced

Patient SS# ____________________
(For insurance purposes only)
***needed to file electronically for services*

Occupation ______________________________________

Employer ____

Employer Address ________________________________

Spouse's Name ___________________________________

How did you hear about Beach Eye Care?

(Select all that apply)

From a Family Member
Name:_____________________
From another BEC Patient
Name:_____________________
From Another Doctor
Name:_____________________
Insurance Carrier
Internet
Facebook
Chamber of Commerce Member
Radio
Newspaper
Yellow Pages
ER/Urgent Care
Beach Eye Care Employee
Previous Beach Eye Care Patient
Walk- In/Drive-By
Hampton Roads Chamber of Commerce

PHONE NUMBERS

Home ( )____________ Work ( )____________

Cell ( )____________

Email ______________________________________

How would you like to receive appointment reminders?:(check all that apply)

Home Phone _____ Cell Phone via Text ______

Postcard _____ Email ______ All Listed (best) _____

Best time and place to reach you by phone?

____

IN CASE OF EMERGENCY, CONTACT
(*Specify someone who <u>does not</u> live in your household*.)

Name:_____________________

Relationship:_______________

Home# ____________ Work#____________

Primary Care Physician_______________________

Primary Care Physician #( )__________________

Pharmacy Name:____________________________

Pharmacy Number:__________________________

INSURANCE

<u>Responsible Party</u>:

Name:______________________________________

Relationship:________________________________

Address:____________________________________

Home ( )___________________________________

Employer:___________________________________

Work ( )____________________________________

Responsible Party Signature:

____

EYE HEALTH HISTORY

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Eye Physician's Name ________________________ **Date of last Visit** ________________________

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

Do you wear glasses	Yes	No	Eye injury	Yes	No	Loss of vision	Yes	No
Blurred vision – distance	Yes	No	Keratoconus	Yes	No	Lazy eye	Yes	No
Blurred vision – near	Yes	No	Glare difficulties	Yes	No	Herpetic keratitis	Yes	No
Burning eyes	Yes	No	Floaters/spots	Yes	No	Double vision	Yes	No
Cataracts	Yes	No	Glaucoma	Yes	No	Crossed eyes	Yes	No
Color vision, poor	Yes	No	Headaches	Yes	No	Light sensitive	Yes	No

Other Surgical History:____

____.

<u>Is there any family history of?</u>

Glaucoma	Yes	No	Relative(s):____________	Diabetes	Yes	No	Relative(s):____________
Retinal disease	Yes	No	Relative(s):____________	Cataracts	Yes	No	Relative(s):____________
Blindness	Yes	No	Relative(s):____________	Keratoconus	Yes	No	Relative (s):_________

OTHER:____

.

Physician's Name _________________________ **Date of last Visit** ___________________________

Have you ever had surgery for or suffered from any of the following medical conditions?

Allergy to Latex Yes No　　　　Allergy to Iodine Yes No

Cold Sores	Yes	No	Date__________	Diabetes	Yes	No	Date___________
Herpes	Yes	No	Date__________	High blood pressure	Yes	No	Date___________
HIV/AIDS	Yes	No	Date__________	Circulation problems	Yes	No	Date___________
Lung disease	Yes	No	Date__________	Heart condition	Yes	No	Date___________
Cancer	Yes	No	Date__________	Stroke	Yes	No	Date___________
Hepatitis	Yes	No	A B or C Circle which applies				

Other:____.

<u>REVIEW OF SYMPTOMS:</u> Please mark ALL that apply

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Change in hair
- ☐ Change in nails
- ☐ Rash
- ☐ Skin lesions
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Difficulty hearing
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Nasal congestion
- ☐ Nasal discharge
- ☐ Nasal bleeding
- ☐ Neck pain
- ☐ Neck swelling
- ☐ Cough
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Back pain
- ☐ Slurred speech
- ☐ Seizures
- ☐ Localized weakness
- ☐ Lymph node swelling
- ☐ Depression
- ☐ Substance abuse
- ☐ Cognitive function delay

List Your Current Medications and Dosage:

____

____

____

____

List ALL Allergies (drug and non drug):

____

____

____

____

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Patient Registration

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In an effort to contain our billing costs, we request that payment be made on the day services are rendered. For your convenience, we accept cash, check, VISA, Master Card and American Express. We also offer the availability of a financing program.

Patients covered by Medicare, Medicaid, Anthem, Champus (Tricare), or HMO's and PPO's of which we are participants, are required to pay their cost share or co-pay on the day of their visit. Patients who have not met their yearly deductible are expected to pay fully for services rendered. Our office must receive required referral forms before we are authorized by your insurance carrier to provide any services, as stated in your health insurance contract.

Blue Cross and Blue Shield claims filed for non-surgery charges become the patient's responsibility after 60 days of non-payment by your insurer. Surgical fees will be filed with both primary and secondary insurance carriers, with payments expected within 90 days from the date of service. Any balance after that time becomes the patient's responsibility.

- Please note that Medicare, Medicaid, and most insurance do not pay for refractions ($42.00 fee)/or after-hours exams (an additional $39.00 fee).
- It is an office policy to charge $35.00 for the third "*no show*" or cancelled appointment with less than 24 hours notice, within a two-year period. A family appointment with three or more appointments in a given day that no show incurs a $35.00 fee for each patient that day. Cancellations for Mondays must be received by 5:00 pm on Friday.

Insurance plans and vision care plans frequently do not cover certain testing that we find important in providing state-of-the-art eye care. These tests (and their fees) are described below so you are well informed as to their need. (If there is a medical diagnosis, thus covered by insurance, we will file to your insurance company.)

Please initial below by each test agreeing to pay the fee(s) indicated if NOT covered by your insurance.

(INITIAL) __________ **Refraction**-A refraction is when the technician or doctor places different lenses in front of your eyes to give the best vision for glasses and/or contact lenses. (fee is $42.00 for a refraction.)

(INITIAL) __________ **Optomap Retinal Exam** –This advanced technology is highly recommended and used by the doctors to detect early signs of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. It is fast, painless, and comfortable. It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the OPTOMAP images can be viewed side by side to discover subtle changes and monitor your continuing eye health. However, new technologies are often not covered by insurance plans. There is a **$49 fee associated with the testing**. Insurance covers this with a medical diagnosis only. The digital images will be reviewed by the doctor in the exam room. This is an alternative to dilation. However, you may still be dilated.

The office staff will be happy to discuss fees with you and fully explain billing and reimbursement procedures. While we do everything possible to assist in obtaining insurance reimbursement, the final satisfaction of the fee for service remains the patient's responsibility.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physicians and authorize the release of any medical information necessary to process my claims. I also understand that I am financially responsible for all services rendered and any fees and /or interest imposed by outside agencies in effort to collect delinquent account balances.

Signature:____**Date**_________________________________

Print Name:____

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Beach Eye Care

Consent for Release of Protected Health Information

I, _________________________, consent to the release of protected health information that is required to carry out treatment or payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Beach Eye Care is not required to agree with my requested restrictions. I also understand that once Beach Eye Care agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a signed written statement.
- I understand that Beach Eye Care must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Beach Eye Care has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the notice accordingly; and we will inform you *on your next visit.*

Individual:	Parent / legal guardian or Witness :
______________________	______________________
Printed Name	*Printed Name*
______________________	______________________
Signature	*Signature*
______________________	______________________
Date	*Date*

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Optical Information

How many pairs of glasses do you have? **1 2 3 4 more**

If you wear glasses are they (**circle**)

For distance **For reading** **For computers**

Bifocals **Trifocals** **Progressive (*no line*)**

Do you wear prescription sunglasses? **Yes** **No**

Do you have difficulty driving at night due to glare? **Yes** **No**

How would you like to improve your current eyewear?

Weight **Thickness** **Fit** **Style**

Shape **Durability** **Size** **Color**

How do you use your eyes for daily or leisure activities: (Circle all that apply)

Computer	**Watching Television**	**Driving**	**Reading**
Needlework	**Sports**	**Golf**	**Swimming**
Hunting	**Fishing**	**Piano**	

Other:___________________________________

Contact Lens Information

How do you wear them?

Daily (take them out nightly) **Continuously (sleep with them in)**
If so, how many days:__________

Please indicate your contact lens brand if known. ______________________________

☐ Monovision ☐ Multifocal

Are your contacts comfortable at the end of the day? **YES** **NO**

Are your contacts comfortable at the end of the wear cycle? (2weeks/1month) **YES** **NO**

How often do you dispose of your lenses? ______________________________

What type of solution do you use? ____________________________________

Patient Copy **For Your Records**

Beach Eye Care

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Beach Eye Care is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

   a. For treatment – Use in acquisition of referrals from PCP offices and referral to other specialists.

   b. For payment – Use in collection of payments.

   c. For health care operations – Use in keeping scheduling books.

2. Beach Eye Care is permitted or required, under specific circumstances, to use or disclose protected health information without the individual’s written authorization.

3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.

4. Beach Eye Care intends to engage in one or more of the following activities:

   a. Beach Eye Care may contact the individual to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to the individual or patient.

   b. Beach Eye Care may disclose protected health information to the sponsor of the plan, group health plan, health insurance issuer, or HMO with respect to a group health plan.

5. The Individual has the following rights regarding protected health information:

   a. The right to request restrictions on certain uses and disclosures of protected health information. Beach Eye Care is not required to agree to a requested restriction.

   b. The right to receive confidential communications of protected health information, as applicable.

   c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

   d. The right to amend protected health information, as provided in the Privacy Regulation.

   e. The right to receive an accounting of disclosures of protected health information.

   f. The right to obtain a paper copy of the notice from the covered entity upon request. This right extends to an individual who has agreed to receive the notice electronically.

6. Beach Eye Care is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

7. Beach Eye Care is required to abide by the terms of this notice currently in effect.

8. Beach Eye Care reserves the right to change the terms of this notice. The new notice provisions will be effective for all protected health information that it maintains.

9. Beach Eye Care will let our patients know of any changes done to the Notice of Privacy Practices at their next visit and the new notice will be posted in the reception area.

10. Individuals may complain to Beach Eye Care and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:

    Patient will fill out the patient complaint form provided to them and the form will then go to the Administrator.

11. Beach Eye Care's contact person for matters relating to complaints is:

    a. April Gregory, HIPAA Officer

b. (757) 425-5550

c. 1201 First Colonial Road, Virginia Beach, VA 23454

12. This notice is first in effect on March 19th, 2003.

13. Beach Eye Care has elected to limit the uses or disclosures that it is permitted to make.

14. Please be aware that parts of your examination maybe overheard by other patients. Let us know if this is a concern and accommodations will be made.