Date: Account: Name:

Peyton Neatrour, MD | Vivek Jain, MD | William Waschler, MD | Edgar Levine, MD

BEACH EYE CARE
Center for Laser Vision Correction
757.425.5550 | BeachEyeCare.com

Mark Lipton, OD | David Tang, OD | Deanna Ritenour, OD | Summer Sayers, OD | Melissa Le, OD
Rebecca Bumgardner, OD | Steven Wilkins, OD

Patient Information

PLEASE PRINT:

Patient Name: _____
Last *First* *Middle*

Name you prefer to be called: _____

Patient SS#_____

Address:_____

City:_____State:_____Zip:_____

Sex: Male/ Female (**circle**) Age:___DOB:____/____/_____

(**circle one**): Single / Married / Separated / Divorced

Race/Ethnicity:_____Preferred Language:_____

Occupation:_____

Employer:_____

Employer Address:_____

Home: (___)_____-_____ Work (___)_____-_____

Cell:(___)_____-_____

Email:_____

How would you like to receive appointment reminders?
__Home Phone ___ Cell phone (text) and/or ___Email

Preferred Doctor:_____

Preferred Location:_____

IN CASE OF EMERGENCY, CONTACT (Does not live with you):
Name:_____

Relationship:_____

Phone Number: (_____)_____-_____

Spouse's Name:_____

How did you hear about Beach Eye Care?

Select all that apply:

Have you heard any of our radio advertisements? ___Yes ___No
If Yes Which Station?_____

Word of Mouth: (select all that apply)
___Doctor Referral :_____
___Family Member:_____
___Beach Eye Care Patient:_____
___Beach Eye Care Employee:_____

Internet: (select all that apply)
___Beach Eye Care Website
___Google or other search engines
___Facebook, or other Social Media
___Groupon/Daily Deal/ Living Social
___Other Internet:_____

Mass Media: ___TV ___Newspaper ___Yellow Pages

OTHER: (select all that apply)
___Insurance Provider Referral
___Best of the Beach
___ER/Urgent Care
___Walk In
___Heath Fair/ Seminar

INSURANCE:
Responsible Party:

Name:_____

Relationship:_____

Address:_____

DOB:_____/____/____ Phone: (____)_____-_____

SS#(for insurance):_____

Responsible Party Signature:_____

1201 First Colonial Rd. Virginia Beach, VA 23454
4388 Holland Rd. Virginia Beach, VA 23452
2173 Upton Dr. Virginia Beach, VA 23454
1501 Cedar Rd. Chesapeake, VA 23322
5386 Kemps River Dr., Virginia Beach, VA 23464
757-425-5550

Account Number:

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 we change our practices, we will modify the notice accordingly; and we will inform you on your next visit.
- Beach Eye Care can discuss my medical and financial information with the following individuals:
  _____

  _____

  _____

  Printed Name:

  _____
  Patient Signature Date

  Guardian Name:_____

  _____
  Guardian Signature: Date

Account Number:

ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare and other third party payer benefits be made on my behalf to Beach Eye care, for services furnished to me by Beach Eye Care. I authorize any holder of medical information regarding myself to release to Center for Medicare Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have a secondary insurance, my signature authorizes releasing the information to the secondary insurance payer, as well. Beach Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the chare determination of the Medicare carrier.

RELEASE OF INFORMATION

Beach Eye Care may disclose all or any part of my medical record and/financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable diseases, or HIV, to any person or corporation (1) which is or may be liable or under contract to Beach Eye Care for reimbursement for services rendered and (2) any health care provider for continued patient care. Beach Eye Care may also disclose on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State and Federal law, statute or regulations. A copy of this authorization may be used in place of the original.

PATIENT PAYMENT POLICY:

The fee schedule of Beach Eye Care is based upon usual and customary fees for the type of service provided. Generally your insurance policy will cover some portion, if not all, of the payment for services provided. **There is, however, no guarantee of payment. The balance amount that your insurance carrier does not cover will be your financial responsibility.**

NON-COVERED SERVICES:

I understand that Beach Eye Care contracts with health care services plans which state what items and services will be covered by the insurance carrier, e.g. Medicare. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the payer to not be covered. For example, our **Refraction and Optomap Retinal Exam.**

- **Refractions –** Technician or doctor places different lenses in front of your eyes to give best vision for glasses or contact lenses
- **Optomap Retinal Exam –** Utilized to detect early signs of retinal disorders, including, but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration and retinal detachment. This is an advanced technology procedure and is often not covered by insurance plans.
- **Tear Osmolarity –** Osmolarity testing has been declared the “gold standard” of objective dry eye diagnosis and the single best marker of disease severity.
- **Adenoplus –** accurately detects adenovirus, which accounts for up to 90% of all viral conjunctivitis, and approximately one out of four cases of acute conjunctivitis seen by eye care practitioners. The patient can then be directed to stay out of school/work during the contagious period and be treated appropriately with antiviral or antibiotic drops.

CONSENT TO TREAT:

I, the undersigned, as the patient or on behalf of the patient, do hereby consent to the authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician, as well as, any testing or diagnostic/screening tests needed for my care.

Patient (or) Guardian Signature:_____Date:

Patient or Gaurdian Name:

Patient Email Address:_____

Account:

CREDIT CARD ON FILE

At Beach Eye Care, we offer to keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. If you chose not to do this, an "outstanding balance" charge of 1.0 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure in Secure Bill Pay, a national financial company that is very protective of an individual's financial information. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. You will receive a statement for the balance and will have 7 days to pay with a different form of payment after the 7 days we will charge the card listed below and will email or mail you a copy of the receipt after your payment is processed.

I authorize Beach Eye Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐MasterCard ☐Discover ☐CareCredit/Alphaeon

Last 4 digits of card number _____

Expiration Date _____ / _____ / _____ 3 Digit Security code:_____

Cardholder Name:

Signature _____

Billing Address _____

City _____ State_____ Zip _____

_____I (we), the undersigned, authorize and request Beach Eye Care to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Beach Eye Care. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Beach Eye Care in writing and the account must be in good standing.

_____ I (we), the undersigned, **DO NOT** authorize Beach Eye Care to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility. I (we) understand I (we) will be responsible for paying these charges today based upon a Patient Cost Estimation, which is derived from the insurance information given and the services received.

Patient Name:

Patient Signature: _____ Date:

Account:

_____ I am here today for my annual eye exam and /or to update my glasses/contact lens prescriptions and would like to use my routine vision benefits only.

_____ I am here today because I am having a problem with my eyes (redness, itching, foreign body, etc.) or to be treated for a medical condition such as glaucoma, diabetes, macular degeneration, cataracts, dry eye, etc., I understand this visit will be filed to my medical health insurance. I will be responsible for any co-pays, coinsurance and deductibles that may apply.

Patient Name: Date:

Signature: _____