



Today's date: _____

PCP: _____

PATIENT INFORMATION

First name: _____ Last name: _____

DOB: _____

Phone #: _____ Prefer Gender: _____

Mailing address: _____

Email address (for appt reminders): _____

How did you hear about us?

Primary Care Provider: _____

Optometrist/Ophthalmologist: _____

Online Patient: _____ Other: _____

EMERGENCY CONTACT

Relationship: _____

Name: _____ Phone: _____

Patient signature: _____ Date: _____

Medical History Form

Name: _____ DOB: ____ / ____ / ____ Today's Date: ____ / ____ / ____
Primary Care Physician (PCP): _____ Pharmacy Name and Location: _____

Personal Medical History (Check All That Apply)

Did you receive the influenza immunization in the last 12 months? Yes No
Did you receive the pneumococcal vaccine in the last 5 years? Yes No
 Diabetes (Year Diagnosed: _____, Last Blood Sugar Level: _____, Last Known HbA1c: _____)
 Cancer (Please Specify: _____)
 High Blood Pressure High Cholesterol Coronary Artery Disease
 Other Heart Problems: _____
 Arthritis Asthma Autoimmune Disease
 COPD / Emphysema Eczema / Dry Skin Hay Fever / Allergies
 HIV / AIDS Sinus Disease Stroke / TIA
 Thyroid Disease Other Medical History: _____
 Past Surgeries and Years of Each: _____

Personal Ocular History (Check All That Apply)

Prescription Glasses Wearer: Current Prescription is ____ Years Old
 Contact Lens Wearer: Hard or Soft (Circle One)
 Amblyopia Cataracts Corneal Disorder
 Diabetic Retinopathy Eye Injury Eyelid Disorder
 Glaucoma Macular Degeneration Retinal Tear / Detachment
 Eye Misalignment (Strabismus, Lazy Eye, Etc.)
 Past Eye Surgeries (LASIK, PRK, Cataract, Eyelid, Etc.) and Years of Each: _____

Family Medical History (Check All That Apply)

Cataract Cancer Diabetes
 Glaucoma High Blood Pressure High Cholesterol
 Macular Degeneration Retinal Tear / Detachment Other: _____

Social History

Smoking / Tobacco: Never Smoker Former Smoker Current Smoker
_____ Packs Per Day
Alcohol: None 1-2 Drinks/Day
 Occasional / Social 3+ Drinks/Day
Recreational Drugs: None Current User
 Former User Type and Frequency: _____

Lifestyle

Do you have difficulty getting around? Yes No
Do you have difficulty looking after yourself? Yes No
Do you live alone? Yes No
Do you drive? Yes No
How many hours do you spend on the computer daily? _____ Hours Per Day
What is your occupation? _____
What are your hobbies? _____

Current Medications (attach a separate sheet if necessary)

Allergies

_____	_____
_____	_____
_____	_____
_____	_____

Doctor's Initials: _____

**This form expires in 1 year.



Consent to Use and Disclose Health Information for Treatment

I FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

As part of your healthcare, Washington Eye Care originates and maintains paper records describing your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. This information serves as: a basis for planning your care and treatment; means of communication among the many healthcare professionals who contribute to your care; a source of information for applying your diagnosis and surgical information to your bill; a tool for third party payors to verify services; and, a tool for continuous quality improvement and the overall continuum of your medical care. This release includes, but is not limited to, the release of information to other physicians' offices, medical facilities, insurance/managed care companies, and the Health Care Financing Administration (for Medicare recipients). Upon request, you are welcome to be provided with the **Notice of Privacy Policy**, which provides a more complete description of information uses and disclosure. You understand my rights to: review the Notice prior to signing this consent; to object to the use of your health information for directory purposes; and, request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or health care operations. Washington Eye Care is not required to agree to restrictions you may apply. You may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. By refusing to sign or revoke this consent, this organization may refuse to treat you as permitted by Section 164.506 of the Code of Federal Regulations. Washington Eye Care reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

Washington Eye Care may disclose your name, address, and phone number; the name of your scheduled treating physician, and time and place of your scheduled appointment(s), for the limited purpose of notifying you of a pending appointment or other healthcare related communication. Washington Eye Care may disclose to third parties who answer your phone limited protected health information regarding pending appointments, and/or leave a reminder message on your voicemail system or answering machine.

Patient or guardian signature: _____ Date: _____

Printed name: _____

*This form expires in 3 years.

I authorize Washington Eye Care to release protected health information, including authorization to discuss account balances and details, with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____



Financial Agreement

I FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

Billing of insurance companies is a service that Washington Eye Care provides to you for your benefit. Possession of a valid insurance card is not a guarantee of payment. Ultimately, the charge for their services is your responsibility. Washington Eye Care will make every effort, on your behalf, to collect payment from your insurance company first. You are responsible for any co-payment at the time of service.

- **Medicare Patients:** Dr. Chen is a Medicare participating provider. This means that Washington Eye Care will bill Medicare for the allowed fees. Medicare pays 80% of the allowed fee and the other 20% is either your responsibility or the responsibility of your Medicare Supplement insurance. You are also responsible for the annual Medicare deductible and all *non-covered services/products. The law requires that you be billed for any applicable deductible and the 20% patient responsibility portion. Our clinic does not submit provider appeals for out-of-network Medicare Advantage plans. You may file a member appeal directly with your plan.

- **Private Insurance:** If you have insurance coverage with a private carrier, Washington Eye Care will make every effort to bill your insurance company first. **It is your responsibility to provide Washington Eye Care with accurate and current insurance information prior to the date of service. If Washington Eye Care is unable to collect payment from your insurance carrier due to incorrect information or rejections, you will be responsible for the entire bill.** You are also responsible for all *non-covered services/products. You may, of course, elect to pay on the day of your visit and then petition your insurance company for reimbursement.

***Non-Covered Services/Products:** There are some services and products that your medical insurance may not cover at all, and payment for these services is your responsibility.

Fee for Service: All payments that are your responsibility are due at the time services are rendered. Washington Eye Care is currently not accepting payment plans.

Medical Records: Your medical records are the legal property of Washington Eye Care and you authorize the release of any medical records needed to ensure payment and coverage for the services that you receive.

Payment: Washington Eye Care accepts cash, VISA, Mastercard, American Express, Discover, or a personal check. There will be a \$25.00 service charge for all returned checks.

You accept financial responsibility for co-payments, deductibles, non-covered services, and claims denied by my insurance company.

You understand that a **\$100** No-Show/Cancellation Fee will be charged if you cancel within 48 hours of your appointment or do not arrive for your scheduled visit.

It is your responsibility to know whether your insurance company requires a referral or prior authorization for your visits to be covered. If a referral or prior authorization is in fact required, it is your responsibility to ensure we get a copy BEFORE your appointment or you may be rescheduled or be responsible for the entire bill if we do not get one.

Signature: _____ Date: _____

**This form expires in 3 years.



Medical vs. Routine Vision Appointments

BY SIGNING THIS, YOU FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

Dr. Chen does not accept vision insurance and does not provide routine eye exams or check-ups for glasses. If you are here only for a routine exam or an updated glasses prescription, please note that we do not offer routine vision services and cannot bill vision insurance. **You may self-submit your refraction receipt to your vision* insurance for possible reimbursement.** *QR codes provided at the front desk to access the reimbursement pages for the most popular vision plans.

All visits here are billed to your medical insurance only. Your medical deductible, copay, or coinsurance will apply.

You are being seen today as a **medical patient**, which means **your visit is for a medical eye problem or condition.** Examples include (but are not limited to): diabetes, macular degeneration, glaucoma, cataracts, corneal problems, eye pain, dryness, flashes/floaters, or any other medical concern.

Patient signature: _____ Date: _____

**This form expires in 3 years.



REFRACTION SERVICE AND FEE

Effective January 1, 2025

A refraction is the part of the eye exam that determines your glasses or contact lens prescription.

It is needed any time we check whether your vision has changed, can be improved, or whether glasses may help. It can also help us decide if you may need other medical or surgical treatment.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations.

Medicare requires that we charge separately for that portion of the examination, since refractions have been determined as a non-covered service.

Our office fee for a refraction is \$80 and this fee is collected at the time of service. This fee is in addition to any co-payments your plan may require on the day of your appointment.

Please note:

The refraction fee covers the time and work involved in performing the test and reviewing the results. This fee is due even if your prescription does not change or if you do not need new glasses. (Just like other medical tests, the cost is for the test itself, not the outcome.)

If you have questions regarding your insurance coverage or policies, **please contact your insurance directly as they will be able to provide your specific plan and coverage information.** We will also do our best to assist you in our office should you have any questions regarding this policy.

ACKNOWLEDGEMENT:

I have read the above information and understand that refractions are a non-covered service by insurance. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, co-insurance, or deductible I may have are separate from the refraction fee.

Patient Signature

Date