

WELCOME!***Your Vision is our Mission.***

Dear Patient:

We appreciate your selection of our office to serve your eye care needs. At Visionary Ophthalmology, we strive to provide our patients with world-class, technologically advanced and efficient eye care, with a loving touch.

We are a full-service General Ophthalmology practice that specializes in:

- **Corneal transplants**
- **Refractive surgery**
- **Laser vision correction**
- **Cataract surgery**
- **Pterygium surgery**
- **Medical retina**
- **Inflammatory diseases**
- **Glaucoma**
- **Contact lenses**

All of our ophthalmologists are board certified by the American Board of Ophthalmology as well as fellowship trained. All members of our staff have been trained to function as a team striving for excellence. We are always implementing highly efficient systems and procedures to enhance the patient's experience.

The date of your exam, we will dilate your eyes so that the doctor can check their overall health. The doctor may request additional tests if necessary. To make your visit go as smoothly as possible, please complete the enclosed registration forms and bring them with you the day of your appointment. Be sure to sign and date where required. ***Also, please bring: your insurance card (including any vision plans), photo ID, and a Primary Care Physician Referral (if your insurance requires one, HMO and POS).***

Please allow at least 2 hours for your exam. (Part of this time is spent waiting for your eyes to dilate). Additional testing may require more time. Contact lens fittings also take extra time.

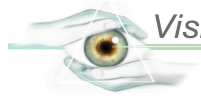
To better serve you, we have an ***Optical-In-House*** with great prices, selection and styles. ***We accept almost all Vision plans.***

We also have a Skin Care center on-site, ***Lumina Skin Center***, dedicated solely to skin care aesthetic procedures, using the latest technologies, treatments and products.

We are looking forward to seeing you. Please feel free to call us if you have any additional questions prior to your visit.

Sincerely,

Visionary Ophthalmology Doctors and Staff



REGISTRATION FORM

DATE: _____
Patient Name: _____ Date of Birth _____ Age _____
Gender [] M [] F Marital Status [] Single [] Married [] Other Social Security # _____
Address: _____ Apt# _____
City/State/Zip: _____
Home #: _____ Cell #: _____ Work#: _____
Please Indicate Preferred Contact Number: _____ Email Address: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____
Referring Physician: _____ Referring Physician Phone #: _____
Primary Care Physician: _____ Primary Care Physician Phone#: _____

-Billing and Insurance Information-

Primary Insurance: _____ Secondary Insurance: _____
ID#: _____ Group #: _____ ID#: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Date of Birth: _____ SS#: _____ Date of Birth: _____ SS#: _____
Relationship to Patient: _____ Relationship to Patient: _____

-Information of responsible party - For minors-

Parent #1: _____ Parent #2: _____
Date of Birth: _____ SS#: _____ Date of Birth: _____ SS#: _____
Address: _____ Address: _____
Home #: _____ Work #: _____ Home #: _____ Work #: _____
Employer: _____ Employer: _____

How Did You hear About Us

Friend/Family: _____ Doctor: _____ Radio: _____
Internet: _____ TV: _____ Other: _____

ARE YOU COVERED BY ANY VISION PLAN? RECEPTIONIST INITIALS:
VSP [] DAVIS VISION [] SPECTERA [] OTHER [] _____

** OPTIONAL INFORMATION **

Annual Income: [] \$0-\$25,000 [] \$26,000-\$35,000 [] \$36,000-\$50,000 [] \$51,000-\$70,000 [] \$71,000-\$100,000 [] \$101,000 and up
Race: [] White/Caucasian [] Hispanic/Latin [] African American [] Indian American [] Asian [] Other
Education: [] High School [] High School Graduate [] Some College [] Bachelor's degree [] Master's degree [] Professional degree [] Doctorate degree



FINANCIAL POLICY

At Visionary Ophthalmology, we strive to provide you with the highest level of service and the best medical care. In return, is your responsibility to provide us with your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

APPOINTMENTS: We request that you keep scheduled appointments and arrive on time. Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment will result in a \$35 fee per patient.

REFRACTION: One of the most important parts of your eye exam is the refraction. A refraction test determines not only your most accurate eyeglass prescription, but also the best possible vision and function of your eye and it helps our Doctors to make a better decision about your treatment options. The Refraction is not considered a "medical service" but a "vision service" and Medicare and most insurance carriers do not cover it. Our office fee for Refraction is \$55.00, and it should be paid at the time of service. We will be happy to bill your insurance company and; should they cover and pay for it, we will reimburse you accordingly.

VISION PLANS: If you have a routine vision plan you must inform the receptionist at the time of check in. Our office participates with most medical insurance plans and routine vision plans. Medical insurance plans will cover medical eye problems, such as dry eye or glaucoma, but they do not cover the cost of glasses, contact lenses, and routine vision care, such as refractions (above). Routine vision plans will cover only routine eye exams, but will not cover a medical eye problem. During your exam, if you are diagnosed with a medical eye problem, we will submit a claim to your medical plan. All vision plans are different, and some of them cover part of the refraction. As a courtesy to you we will try to verify benefits prior to your visit.

CONTACT LENSES: In most cases medical insurance and routine vision plans do not cover the cost of contact lens evaluation, prescription verification, or fitting. The charge for these contact lens services is a separate and additional charge to the eye exam. The charge for these services varies between \$50 to \$300, depending on the complexity of the contact lens prescription, the type of contact lens being fit, and the need for instruction on contact lens insertion and removal. Please inform our staff when you make the appointment and at the time of check in if you would like to be fit with contact lenses, or if you would like your contact lens prescription updated or verified.

RETURNED CHECKS: Any payment made by check that does not clear your bank account will result in a fee for insufficient funds. Our fee for insufficient funds is \$40.00 and will be added to your account for each bounced check.

CO-PAYS/DEDUCTIBLES: According to your insurance contract, you are obligated to pay any co-payment due at the time of service. If you are unable to pay the co-pay at the time of service, we reserve the right to cancel or reschedule your appointment. It is our policy to collect all patient co-payment amounts at the time services are provided. It is also our policy to bill for all non-paid amounts and to pursue collection efforts with regard to deductibles and under-payment.

SELF PAY /NO INSURANCE: If you are the sole party responsible for all charges incurred we ask that you make your payments at the time of service. If your treatment is extensive, or you require any type of surgical procedure including any refractive procedures, we offer 0% financing for up to 12 months with Care Credit and Chase Health Advance to help make your payments more manageable.

HMO PLANS/REFERRALS: Managed care plans require us to have a valid authorization or referral at the time of service. If you do not have a referral at the time of your visit your appointment can be rescheduled until you obtain a referral. The referral is your responsibility. If you choose to be seen without a referral, payment in full will be required at the time of services.

SURGERY: CANCELLATION FEE: There is a \$150.00 administrative fee if wish to cancel or change the date of surgery and notice is not provided at least 3 days prior to surgery. **Post Surgical Kit:** Insurance companies do not cover the cost of post surgical kits (\$20.00), therefore it will be the patient's responsibility to assume such payment.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

Name of Patient

Signature of Patient or Pat. Representative)

Date



PRIVACY ACT NOTICE FOR PATIENT

Use and Disclosure of Protected Health Information

Our “Notice of Privacy Practices” policy, available at the front desk at Visionary Ophthalmology and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated.

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 Notice of Privacy Practices and consent Visionary Ophthalmology 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**.

Signature : _____

Date: _____

Printed Name: _____

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

Authorization for use of Patient Contact Methods

We might be unable to contact patients directly during normal business hours. On these occasions our office contacts patients and leaves messages through the communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose 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.

Yes, I agree to allow Visionary Ophthalmology to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account.

No, I do not agree to allow Visionary Ophthalmology to leave messages that includes Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email

Signature on File, Assignment of Benefits, Financial Agreement

1) **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Visionary Ophthalmology, for services furnished to me Visionary Ophthalmology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Visionary Ophthalmology and authorizes the release of medical information necessary to pay the claim. Visionary Ophthalmology accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2) **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Visionary Ophthalmology, if possible, or otherwise to me.

3) **OTHER INSURANCE:** I understand that Visionary Ophthalmology participates in several medical insurance plans. It is my responsibility to determine physician participation in my plan, coverage, applicable co-pays and any other requirements of my policy. I understand my signature requests that payment be made to Visionary Ophthalmology and authorizes release of medical information necessary to pay the claim. I am responsible for the deductible, coinsurance, co-pay, and non-covered services.

4) **MINOR PATIENTS:** I understand that as the parent/guardian accompanying the patient, I will be fully responsible for payment of services rendered.

5) **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Visionary Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Visionary Ophthalmology. I understand Visionary Ophthalmology contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. The undersigned accepts full financial responsibility for any non-covered services, co-pays, deductibles, co-insurance or unauthorized services. If my account is sent to a collection agency, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Name

Date

Signature of Patient or Authorized party

Printed name (if not patient)