Patient Form

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Cell Phone | Home Phone

Email

Preferred Contact Method *Cell Phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Patient Date of Birth | Male/Female

Occupation/Employer | *Full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language

Race *White* | *Asian* | *American Indian/Alaska Native* | *Black/African American* | *Native Hawaiian/Pacific Islander* | *Decline*

Ethnicity *Hispanic or Latino* | *Not Hispanic or Latino*

Emergency Contact Person and Phone

INSURANCE INFORMATION

Primary Medical Insurance

Member Name

Insurance ID# | Insurance Policy#/Group ID#

Member Date of Birth | Member Social Security Number

Member Employer

Patient relationship to member *self* | *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Member Name

Insurance ID# | Insurance Policy#/Group ID#

Member Date of Birth | Member Social Security Number

Patient relationship to member

Vision Insurance *(list all if applicable)*

Member Name | Primary Member Date of Birth

Insurance ID#

Primary Care Physician Name and Phone

Patient Form

EYE HISTORY

Date of Last Exam		
Currently Wear Glasses?	*Yes*	*No*
Currently Wear Contacts?	*Yes*	*No*
Brand if Yes:		
Any Eye Surgery? List		
Reason for today's visit		

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	Yes	No	Family
Crossed Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LAZY Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ○ Blurry Vision *near or distance*
- ○ Burning
- ○ Discharge
- ○ Double Vision
- ○ Dryness
- ○ Excess Tearing/Watering
- ○ Eye Infection
- ○ Eye Infection
- ○ Eye Pain or Soreness
- ○ Floaters or Spots
- ○ Halos
- ○ Headaches
- ○ Itching
- ○ Light Flashes
- ○ Light Sensitivity
- ○ Redness
- ○ Sandy or Gritty Feeling

NOTES/ADDITIONAL INFORMATION

MEDICAL HISTORY

Have you or a family member experienced or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*Yes*	*No*	*Family*
Allergies	*Yes*	*No*	*Family*
Arthritis	*Yes*	*No*	*Family*
Stroke	*Yes*	*No*	*Family*
Thyroid Dysfunction	*Yes*	*No*	*Family*
Asthma	*Yes*	*No*	*Family*
Blood/Lymph Disorder	*Yes*	*No*	*Family*
Skin Conditions	*Yes*	*No*	*Family*
Cancer	*Yes*	*No*	*Family*
Diabetes	*Yes*	*No*	*Family*
Ears, Nose, Throat Conditions	*Yes*	*No*	*Family*
Gastrointestinal Conditions	*Yes*	*No*	*Family*
Heart Disease	*Yes*	*No*	*Family*
High Blood Pressure	*Yes*	*No*	*Family*
High Cholesterol	*Yes*	*No*	*Family*
Kidney Disease	*Yes*	*No*	*Family*
Lupus	*Yes*	*No*	*Family*
Neurological Conditions	*Yes*	*No*	*Family*
Psychiatric Disorder	*Yes*	*No*	*Family*
Seizures	*Yes*	*No*	*Family*

Current Medications (prescription and over the counter and dosage)

Medication Drug Allergies

Height	**Weight**		
Are you Pregnant or Nursing?	*N/A*	*Yes*	*No*
Do you smoke?		*Yes*	*No*
Have you ever smoked?		*Yes*	*No*

REFRACTION POLICY AND FINANCIAL RESPONSIBILITY AGREEMENT

Most medical plans, including Medicare, do not cover refractions or routine eye examinations (when NO medical eye problem is known or suspected). If your examination includes refraction, there will be a $35.00 additional fee, since it is not a covered service.

I HEREBY AUTHORIZE THIS OFFICE TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED. I THROUGHLY UNDERSTAND THAT MY INSURANCE IS AN AGREEMENT BETWEEN THE INSURANCE PROVIDER AND MYSELF, NOT BETWEEN THE INSURACE PROVIDER AND THE MEDICAL OFFICE. IF AUTHORIZATION IS REQUIRED FROM MY PRIMAY CARE PHYSICIAN, I HAVE TO OBTAIN SUCH DOCUMENT(S) PRIOR TO MY VISIT. I THEREFORE AGREE THAT THE PAYMENTS FROM INSURANCE COMPANIES BE MADE TO OPTOMETRIC CONSULTANTS OF VIRGININA, INC. (d.b.a. Eye & Vision Care). I ALSO UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR MY MEDICAL SERVICES RENDERED. I CERTIFY THAT INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL RECORDS, TO DETERMINE INSURANCE BENEFITS TO WHICH I MAY BE ENTITLED.

_____ _____

Patient, Parent or Guardian's Signature Date

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctors at Optometric Consultants of Virginia, Inc. d.b.a Eye & Vision Care to get a better view of the inside of your eye.

Dilating drops blurs the near vision. It does not affect the distance vision but light sensitivity can make driving difficult afterwards. It is not possible for your optometrist to predict how much your vision will be affected. You may need driver afterwards.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Dimple Kapoor, O.D and/or associates, or such assistants as may be designated by her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient, Parent or Guardian's Signature Date

NOTICE OF PRIVACY PRACTICES

Our notice of privacy practice provides information about how we may use and disclose protected health information (PHI) about you. The notice contains patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we Change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Patient, Parent or Guardian's Signature Date

South Riding, Haymarket, Ashburn, and Fairfax

Refund, Return, Redo and Cancellation Policy

By signing below you agree to the following terms;

1. **Contact Lens:**
    a. All contact lenses purchased from us can be exchanged for up to 12 Months for all and **only unopened and clean** boxes. ****(additional administrative costs may apply) (No Refund)**
2. **Prescription eyewear cannot** be returned for refund. (Warranty and exchanges may apply.) See below;
3. **Frames:**
    a. All frames except closeouts or discontinued (please ask the optician to help you with that) are warranted against **defects in workmanship for a period of one year from date of purchase.
    b. Frames may be exchanged for full credit (**No Refund**) one time for patient satisfaction up to 10 days from date of purchase. **Lens fees may apply. See Optician for details.**
4. **Prescription Lenses:**
    a. Lenses will be made and inspected to the specification of the prescription given and with the material and options you have selected. If the lens fails as a result of a manufacturers defect for a period of one year from purchase date we will replace with the identical item in the original prescription at no charge to you.
    b. **ONE Redo** of lenses due to doctors' change or any change in prescription within 90 days of purchase can be performed at **no charge**.
5. **Coatings:**
    a. ***Anti reflection coatings** are warranted with full lens replacement at no cost to the customer for a period of one year from date of dispense for coating failure including hairline scratches, peeling and crazing.
    b. **Scratch coated** lenses with manufacturer supplied scratch coatings are warranted and will be replaced one time for a period of one year from date of purchase with the original lens and RX.
6. **Non-adapt policy:**
    a. Progressive lenses - If for any reason you are not able to adapt to using the Progressive/multifocal lens we will replace those lenses within 60 days of receipt with either a pair of single vision distance and near lenses or lined bifocal. **No refunds.**
7. **Cancellation:**
    a. In the event you wish to cancel your order it must be done by the **close of business on the day of order** to receive a full refund.
    b. All costs incurred once a prescription order has been started at the lab whether or not completed will be the customers' responsibility therefore may not be eligible for **full refund.**
    c. In the event you cancel an appointment without 24 hour notice; you will be responsible for **$50.00** in broken appointment fees.

+++ All cancellations once approved will be refunded with Check ONLY.

** Scratches and fatigue from obvious abuse are not considered defects. Manufacturer guidelines will apply.
*** Ultra AR coatings may have extended warrantees, please check with optician.
**** Admin and re-stocking fee will apply.

Patient/Guardian or Parent Signature	Full name of the Signee	Date

3903-E Fair Ridge Drive Fairfax VA 22033
25055 Riding Plaza Ste#100 Chantilly VA 20152
5511 Riding Plaza Haymarket VA 20169
21001 Sycolin Rd. Ste#140 Ashburn VA 20147
PH:703.961.9119 e-mail: info@eyeandvisioncare.com

Vision vs Medical Insurance

Many people have both vision and medical insurance. They are different in terms of the services they cover and it is important for our patients to understand these differences.

Vision Coverage (VSP, Davis Vision, Eyemed, Spectera) is mainly designed to determine a prescription for glasses or contacts and is not equipped to deal with complex medical conditions and or/ diagnosis. It does allow for screenings of conditions, but once they are determined, then we are required to file the medical insurance for those services.

When a medical condition is present (such as diabetes, cataracts, dry eyes, floaters, etc), it is necessary to File the visit with your major medical carrier (Blue Cross, Aetna, United Healthcare, Medicare, Cigna, etc.) and co-pays set by your insurer will apply as well as any non-covered services.

Insurance carriers set these rules and our office is legally obligated to be compliant. In most cases, there is no way to guarantee which plan we will be required to file prior to the examination. We make every effort to be a provider for all major carrier for your convenience and we will file those claims for you. In the event that we do not accept your insurance, we will provide you with itemized receipt so you may file with your carrier for reimbursement. If you have any questions please let us know.

I _____understand the paragraphs above and authorize Eye & Vision Care and associate doctors to file my insurance by the above guidelines.

Signature:_____Date:_____

3903-E Fair Ridge Drive Fairfax VA 22033
25055 Riding Plaza Ste#100 Chantilly VA 20152
5511 Riding Plaza Haymarket VA 20169
21001 Sycolin Rd. Ste#140 Ashburn VA 20147
PH:703.961.9119 e-mail: info@eyeandvisioncare.com

Name _____ Date _____

Check all symptoms experienced since last visit.

- ☐ Dry Eyes
- ☐ Blurry Vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excessive tearing/watery eyes
- ☐ Tired eyes/eye fatigue
- ☐ Stringy mucous in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy, feeling of sand or grit in eye
- ☐ Fluctuating Vision

Have you used any eye drops in the last 2 hours?

- ☐ Yes
- ☐ No

FOR OFFICE USE ONLY – OSMOLARITY MEASUREMENTS

Doctor's Order initials _____ Date _____

Right Eye (m0sms/L)_____ Left Eye (m0sms/L_____

Osmolarity ☐ Normal ☐ Abnormal

Schedule for Dry Eye Workup ☐ Yes ☐ No