BLUE RIDGE
OPHTHALMOLOGY
Eye Physicians & Surgeons

ASHLEY SCHAUER, M.D. ~ ANDREW COLLINS, M.D. ~ RITA PAGE, M.D. ~ PETER BLOSSER, M.D.

Dear New Patient,

Thank you for scheduling a visit with us.

Please come 15 minutes before your appointment to allow for parking and finding the office.

- Please take a few moments to fill out the following paper work, and **bring it with you to your appointment.**

- If you need to cancel your appointment or reschedule please give us a 24-hour notice.

- Please bring your insurance card, driver's license/picture ID and glasses in with you. **If you have a vision care plan, we do not participate with these plans and will only bill your insurance if something is medically wrong with your eyes.**

- If you wear contact lenses please bring an unopened sample or a written prescription for them from your previous eye doctor

- If this is a pre-deployment exam, we will not bill your vision care plan and you will be responsible for your bill and can seek reimbursement from your employer

- Bring a complete up-to-date medication list or all of your medications including eye drops with you

Notice to Our Patients Regarding the Refraction Charge

- Refraction is the procedure in which we determine the best corrected visual acuity of each eye for purposes of medical evaluation or for prescribing spectacles or contact lenses. For most insurances, including **Medicare**, there is no provision for coverage of this procedure and there is no indication that it will likely become a covered service anytime in the future.

- Refraction is necessary to adequately determine visual function and is important in making sure that serious underlying eye problems do not exist. We perform refractions as a part of all of our comprehensive eye evaluations.

- We trust that you will understand the need to perform this procedure and we respectfully ask for payment at the time of service

Thank you for selecting us for your eye care. We look forward to seeing you.

Drs. Schauer, Collins, Page, Blosser and Staff

434~295~3227 ~ fax 434~295~9527 ~ blueridgeeyemd.com ~ 626 Berkmar Circle ~ Charlottesville, VA 22901

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NAME: _____ **Date of Birth:** _____
(First) (Middle Initial) (Last)

Gender (circle): Male / Female **Social Security number:** _____ - _____ - _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone number: (Home)_____ **(Work)**_____ **(Mobile)** _____

Marital Status: _____ **Contact preference (circle):** Home phone / Cell phone / Text message / Email

Email Address:_____ **Employer:** _____

Who referred you? _____ **Primary Care Doctor:** _____

The following is requested for the Meaningful Use Project directed by the Dept. of Health and Human Services (HHS)

Race (circle): Hispanic / White / Asian / Black/African American / American Indian
Hawaiian/Pacific Islander / Other

Ethnicity (circle): Hispanic / Non-Hispanic / Unknown

Primary Language (circle): English / Spanish / Other: _____

Smoking History (circle): Every Day Smoker / Some Days / Former / Never Smoked

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Financial Responsibility (If you are a minor or someone else is responsible for payment)

Name: _____ **Relationship to Patient:** _____

Social Security Number: _____ - _____ - _____

Address: _____

Phone number: (Home)_____ **(Work)**_____ **(Mobile)** _____

I hereby authorize payment directly to Blue Ridge Ophthalmology (Drs. Schauer/Collins/Sanders) all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf. I authorize the above noted doctor and/or any provider or supplier of service in this office to release information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that obtaining a referral from my primary care doctor does not guarantee insurance coverage for this visit.

For Medicare patients (and some other insurance carriers): I request that payment under the Medicare Insurance Program be made to me or on my behalf to the above noted doctor for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. Furthermore, I am aware that the Medicare program may not pay for all services rendered. For example, routine eye examinations and determining glasses' prescriptions ("refractions") are not Medicare benefits.

I understand that any unpaid balance that is not covered by insurance may be turned over to a collection agency with failure to pay within (3) billing cycles, and I agree to pay the cost of collection, court costs and reasonable attorney fees. I also agree to pay interest on any outstanding balance with failure to pay on (3) billing cycles at the rate of 18% annually.

Signature: _____ **Date:** _____

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Patient: _____

Reason for today's visit:

Medical History / Systems Review (list or write none) *(may continue on back)*

General: _____
Ears/Nose/Throat: _____
Heart/Blood Vessels: _____
Lungs/Breathing: _____
Stomach/Intestines: _____
Kidneys/Bladder/Prostate: _____
Joints/Muscles: _____
Skin: _____
Brain/Nerves: _____
Mental Health: _____
Endocrine/Diabetes: _____
Blood: _____
Allergy/Immune: _____

Social History:

Occupation: _____ Smoking: _____

Your Eye History *(check all that apply):*

□ None □ Glasses □ Contact Lenses: soft / hard □ Lazy Eye □ Cataract □ Macular Degeneration □ Glaucoma
□ Diabetic Retinopathy □ Eye Injury(s): _____
□ Eye Surgery(s): _____

Family Eye History *(check all that apply):*

□ Glaucoma □ Macular Degeneration □ Cataract □ Lazy Eye □ Cancer of Eye
□ Other: _____

Allergies to Medicines *(list):*

_____ _____ _____ _____
_____ _____ _____ _____

Medications *(please list):*

_____ _____ _____ _____
_____ _____ _____ _____

Are you taking Coumadin (blood thinner)? Yes / No
Are you taking Flomax or other urination medicine? Yes / No

Surgeries *(list):*

_____ _____ _____ _____
_____ _____ _____ _____

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HIPAA Notice of Privacy Practices

I, _____ ***(print name),*** understand that as part of my healthcare this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and plans for future care. I understand that this information serves as: A basis for planning my care and treatment, a means of communication among the health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of the healthcare professional.

A Privacy Notice from Blue Ridge Ophthalmology, PLLC has been made available that provides a more complete description of information uses and disclosures. I have the right to review the notice prior to signing this consent. I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. ***I wish to have the following restrictions to the use or disclosure of my health information:***

May we leave messages / medical information on a voicemail at either of these phone numbers?

□***Yes*** □***No*** ***Home Phone:***_____ □***Yes*** □***No*** ***Cell Phone:*** _____

May we contact you at your place of employment*?* □***Yes*** □***No***

If so, may we leave a message? □***Yes*** □***No***

If yes: Work Phone: _____ ***Extension:*** _____

Do you have any particular person or family member(s) that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□***Yes*** □***No*** ***If yes, please provide:***

Name: _____ **Relationship:** _____

Phone Number(s): _____

Is this person your Power of Attorney for medical purposes? □***Yes*** □***No***

I hereby authorize Blue Ridge Ophthalmology to obtain or release any and all pertinent information regarding my medical care, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities and other institutions. This notice and authorization remains in effect until revoked.

I fully understand and accept the terms of this consent.

Patient Signature: _____ **Date:** _____

S:/OFFICE FORMS/HIPAA One Sheet

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REFRACTION (GLASSES EXAM) SERVICE AND FEE

Refraction is the part of a complete eye examination in which the glasses or contact lens prescription is determined (the "Which is better, one or two?" test). **A refraction is not performed every visit, but is necessary if you want a prescription for new glasses, or updating your contact lenses.**

Most medical insurance plans, including Medicare, do not pay for the refraction part of the eye examination *(Medicare has never paid for this service)*. Furthermore, they require that we charge a separate fee for that portion of the eye exam.

An exception to this is that some insurance and **vision care plans** cover routine or annual eye examinations, including refraction for new glasses. Your vision plan may help pay for your eye care needs that are not covered by your medical plan. If you have such coverage, please let us know so that we can provide you with a receipt of payment, however **we do not participate in vision care plans and will not bill your insurance for the refraction.**

Our office fee for refraction is $60.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your insurance plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from, and not included in, the refraction fee.

_____ _____

Patient Signature (Parent for Minor) Date

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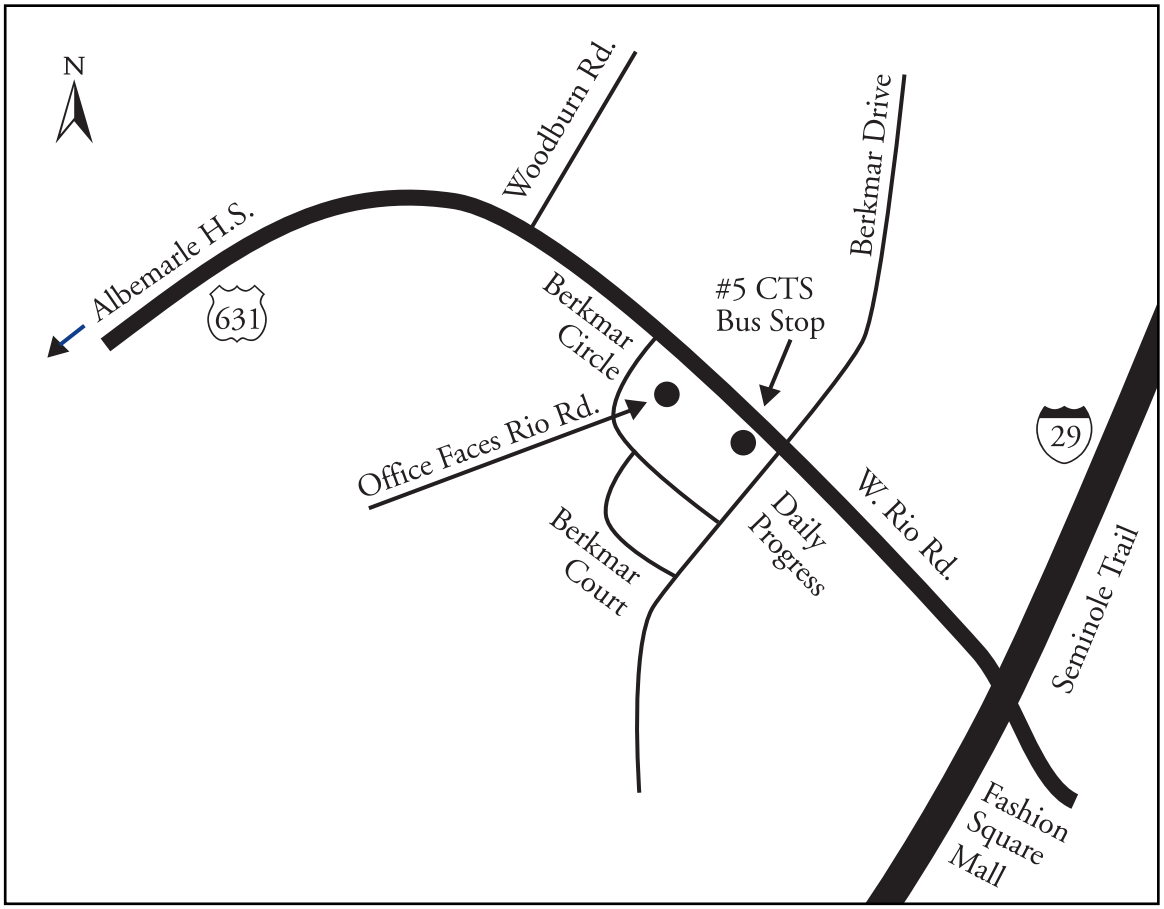
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Directions

We are at 626 Berkmar Circle, within the Berkmar Crossing Shopping Center. ***Our building faces Rio Road.***

From Route 29 South, heading north toward Wal-Mart, turn left onto Rio Road. Coming from the North, heading south toward Fashion Square Mall, turn right onto Rio Road. Pass through the next stop light at Berkmar Drive. Turn left into the shopping center just past the light. Our building is the only one story building on the left facing Rio Road.

If you are unfamiliar with the area and you need further assistance, please call us before the day of you appointment and we will be glad to give you more detailed instructions.



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