VIRGINIA ADULT AND PEDIATRIC OPHTHALMOLOGY, PC
5900 FORT DRIVE, SUITE 301
CENTREVILLE, VA 20121

1.PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ M_____

DATE OF BIRTH_____ GENDER M F

STREET ADDRESS _____ HOME #_____

CITY/STATE/ZIP_____ CELL #_____

*PRIMARY MEDICAL INSURANCE _____

ID#_____ GROUP#_____

POLICY HOLDERS NAME:_____POLICY HOLDERS DATE OF BIRTH_____

POLICY HOLDERS RELATIONSHIP TO THE PATIENT: _____SELF _____SPOUSE _____DEPENDANT

POLICY HOLDERS SOCIAL SECURITY # :_____ **THIS REQUIRMENT IS FOR MEDICARE AND TRICARE PATIENTS ONLY, ALL OTHER INSURANCE PLANS, N/A.

*SECONDARY/SUPPLEMENTAL MEDICAL INSURANCE _____

ID#_____ GROUP#_____

POLICY HOLDERS RELATIONSHIP TO THE PATIENT: _____SELF _____SPOUSE _____DEPENDANT

POLICY HOLDERS SOCIAL SECURITY # :_____ **THIS REQUIRMENT IS FOR MEDICARE AND TRICARE PATIENTS ONLY, ALL OTHER INSURANCE PLANS, N/A.

2. WHO IS YOUR PRIMARY CARE PHYSICAN? _____

3. WHAT IS THE NAME OF YOUR PREFERRED PHARMACY?_____

_____

4. HOW DID YOU HEAR ABOUT OUR OFFICE? (PLEASE CIRCLE AN OPTION BELOW)

1. DOCTOR REFERRAL (NAME OF DOCTOR WHO REFERRED YOU_____)
2. FRIEND OR FAMILY MEMBER
3. INTERNET SEARCH (GOOGLE, BING, YELP, ETC)
4. INSURANCE COMPANY REFERRAL
5. KOREAN NEWSPAPER/KOREAN DIRECTORY
6. OTHER _____

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5. PLEASE READ OVER THE FOLLOWING OFFICE POLICIES AND SIGN AT THE BOTTOM

A. CANCELLATION AND NO SHOW POLICY

I agree to pay a $25.00 fee for appointments not cancelled prior to 24 hours of the designated appointment time. (except for emergency situations)

B. HMO PATIENTS/REFERRALS

I understand that if my insurance plan requires a referral, it is my responsibility to obtain that referral prior to my visit. Virginia Adult and Pediatric Ophthalmology reserves the right to reschedule any appointments for HMO patients who have not obtained the necessary referral prior to their appointment.

C. FORM FEES AND COPYING OF MEDICAL RECORDS

I understand that there will be a reasonable fee charged for the copying of medical records and to fill out forms (i.e school forms, DMV forms). The price charged for forms will be calculated by the complexity and time required to fulfill the request.

DMV/School forms: $15.00

Drafted letters: $30.00

D. REFRACTION POLICY

A refraction is a necessary procedure done to evaluate your vision *and/or* write you a prescription for glasses. If you are experiencing blurred vision or decreased visual acuity as measured by the eye chart, a refraction would help to determine whether the difficulty is associated with a medical problem or a need for glasses. During the refraction, Dr. Chong or the technician offers you a series of lens choices until you reach the best corrected vision. Unfortunately, not all insurance plans cover this service and Medicare specifically excludes refractions as a covered benefit. The cost of the refraction is $45.00. This payment is due at the time of service for Medicare patients and specific commercial insurances that don't cover it. We will attempt to submit the refraction to your insurance for payment. If your policy determines that it is a non-covered service, then we will bill you.

굴절검사

원시, 근시, 난시를 굴절이상이라고 하는데, 이 굴절이상의 정도를 측정하는 것을 굴절검사라고 합니다. 굴절검사(또는 시력검사)는 안과검사의 가장 기본적이고도 중요한 검사이며, 눈에 이상이 있거나 안경을 위한 처방을 위해서는 반드시 행해야 하는 필수검사입니다.

그런데 이 검사비용을 모든 보험회사 (특별히 메디케어인 경우)에서 지불하지는 않습니다. 만일 환자 본인의 보험회사에서 지불하지 않을 경우에는환자분께서 검사비 45 불을 내셔야 됨을 알려드립니다.

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E. INSURANCE BILLING AND DEDUCTIBLES

Any services provided at Virginia Adult and Pediatric Ophthalmology are considered *"medical,"* and will be billed under your *medical* insurance plan. **We do not participate with any vision plans such as VSP, Spectara, EyeMed, or Davis Vision.**

Keep in mind that since your medical insurance will be used for your visit, policies with an annual deductible may result in an increase to your total out of pocket expense. Insurance plans vary from year to year, so we encourage you to stay up to date and informed on any potential changes to your own policy (increase in deductible amount, institution of a deductible when you never had one before). Call your insurance company with any questions about your specific policy, coverage, benefits, or limitations.

I, the undersigned, have read and agree to all the office policies above and give my authorization to treat and assign directly to Virginia Adult and Pediatric Ophthalmology, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to serve the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service and that I, the patient or patient's representative, am/is responsible for payment of all charges for services rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ _____

PATIENT OR PARENT SIGNATURE (IF PATIENT IS UNDER 18) DATE

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6. AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

At Virginia Adult and Pediatric Ophthalmology, we take patient privacy very seriously. In order for us to communicate with anyone on a patients behalf, we need specific guidelines set forth by the patient (or the patients parent or guardian if a minor).

Please list below any friends or family members that you would like to authorize access to your medical record or give permission to call on your behalf (make or cancel appointments, request invoices, ask questions about visits). List only personal (family, friends) and not professional (other doctors).

I authorize my physician and/or administrative and clinical staff of Virginia Adult and Pediatric Ophthalmology, PC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in situations described in the Notice of Privacy Practices.

NAME OF PERSON/ENTITY	RELATIONSHIP	PHONE NUMBER

7. NOTICE OF PRIVACY PRACTICES UNDER HIPAAA

I have been provided a copy of the office Notice of Privacy Practices required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and understand and consent to the use and disclose of protected health information about myself for treatment, payment, and health care operations.

PATIENT OR PARENT SIGNATURE (IF PATIENT IS UNDER 18) _____ DATE _____