EYE ASSOCIATES OF WASHINGTON, D.C., P.C.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

REFERRED BY:_____ ACCOUNT NUMBER:_____

PATIENT NAME:_____
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS:_____ APT/UNIT #:_____

CITY:_____ STATE:_____ ZIPCODE:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

EMAIL ADDRESS:_____

MALE ☐ FEMALE ☐ MARITAL STATUS:_____

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____

EMPLOYER:_____ ADDRESS:_____

IN CASE OF EMERGENCY:_____ PHONE:_____

NEAREST RELATIVE:_____ PHONE:_____ RELATION:_____

INSURANCE INFORMATION (PLEASE PROVIDE ALL INSURANCE CARDS)

PRIMARY INSURANCE:_____ PHONE:_____

SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____ SS #:_____

ID #:_____ GROUP:_____ DATE EFFECTIVE:_____

SECONDARY INSURANCE:_____ PHONE:_____

SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____ SS #:_____

ID #:_____ GROUP:_____ DATE EFFECTIVE:_____

PHARMACY INFORMATION

NAME:_____ PHONE:_____

ADDRESS:_____

I, _____ HEREBY AUTHORIZE EYE ASSOCIATES OF WASHINGTON, D.C., P.C. TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SREVICES RENDERED. I REQUEST PAYMENT FROM MY INSURANCE COMPANY, PRIMARY AND SECONDARY, BE MADE DIRECTLY TO THE ABOVE NAMED PROVIDER. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE RECEIVING AND READING THE PATIENT INFORMATION SHEET ABOUT INSURANCE.

_____ _____
DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

DESIGNATED PHYSICIAN

DR. P GAVARIS ☐ DR. ASHBURN ☐ DR. BUTTROSS ☐ DR. L. GAVARIS ☐ DR. STRO ASHBURN ☐

EYE ASSOCIATES
OF WASHINGTON DC

PAUL T. GAVARIS, M.D.
FRANK S. ASHBURN, JR., M.D.
F. STROTHER ASHBURN, III, M.D.
MELANIE J. BUTTROSS, M.D.
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OPHTHALMOLOGY | OCULOPLASTIC SURGERY | OPHTHALMIC SURGERY | CORNEA & EXTERNAL EYE DISEASE | GLAUCOMA

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information regarding how *Eye Associates of Washington, D.C., P.C.* 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 the terms described. Should this happen, we will post the changes in all offices.

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 to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.

_____ _____

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf of *Eye Associates of Washington, D.C., P.C.* for any services furnished to me by that physician or supplier.

I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its' agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services.

I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____ _____

Patient's Signature Date

_____ _____

Print Full Name Date of Birth

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)

Name or specifically identify these persons and/or 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 USPS MAIL, ANSWERING MACHINE AND/OR VOICEMAIL

Eye Associates of Washington, D.C., P.C. physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on 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, mobile phone, patient portal account, and current home address on file would include, but is not limited to: test/lab results, prescription/pharmacy information, patient plans, future orders, appointment instructions for visits and procedures, and clinical information.

_____ (Initial) I agree to allow *Eye Associates of Washington, D.C., P.C.* physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____ **Home number**	_____ **Patient Portal**
_____ **Work number**	_____ **USPS Mail**
_____ **Mobile number**	_____ **E-mail**

_____ (Initial) No, I do not agree to allow *Eye Associates of Washington, D.C., P.C.* physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work nor cell phone.

Patient's Signature	Date

For EAWDC Internal Use Only:

UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on _____/_____/_____, but was unable for the following reason:

_____

EAWDC Employee Signature	Date

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FINANCIAL POLICY

At Eye Associates of Washington, DC, we are committed to providing you with the highest level of service and quality care. If you have medical insurance, it is your responsibility to provide our practice with your insurance information to help you receive your maximum allowable benefits. However, all financial liability rest with the patient. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

Insurance Companies and Non-Covered Services

Our office participates with many major insurance companies. It is patient's, parent's, guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- It is your responsibility to find out from your insurance company if the insurance company will cover the service provided.
- Please bring all your current insurance cards to all visits.
- Provide our practice with current information including address, phone numbers, email address and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay and or deductibles at each visit.

We accept cash, checks and all major credit cards for service.

- Evaluation and purchasing of contact lenses are frequently not covered by insurance companies. Full payment is due when contact lenses are ordered.
- Most insurance companies, including Medicare, do not cover a Refraction**.** Our office fee for a refraction is **$65.00**. This fee is collected at the time of your visit in addition to any co-payments and/or deductibles.
- We provide medical, surgical and cosmetic ophthalmologic care to our patients, and while we also provide routine eye exams to our patients with no medical complaints, we do not accept ANY vision plans or bill health insurance for these routine exams. You may submit a claim to your insurance to try and seek reimbursement for routine services. Our charges are available upon request.

*** If you do not have a medical complaint you will be financially responsible for all charges at the time of service.**

Outstanding Balances:

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to a collection agency, you agree to pay fees imposed by the collection agency to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **$30.00** returned fee.

Referrals

If you have a managed care plan that requires a referral to see a specialist, you **must** obtain a referral for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to sign a waiver and pay for the visit prior to your examination.

Continued on the back

Refractions

If you receive a prescription for glasses or contact lenses you will be charged **$65.00** if your insurance company does not cover it, which is payable at the time of the visit.

Forms

There is a charge for completing various forms, including DMV vision forms. Pre-payment is required for completing forms, or for any written communication by the doctor.

Common Fees

SERVICE	CHARGE	PAYABLE
Refraction	$65.00	At time of service
Rapid Viral Test	$50.00	At time of service
DMV Vision Form	$30.00	Upon acceptance of form
Disability Form/Doctor Letter	$40.00	Upon acceptance of letter
Self-Pay Patients		At time of service
Non-Covered Services		At time of service
Cosmetic Services (Botox®, Dermal fillers, Surgery)		At time of service/2 weeks prior to surgery
Premium Cataract Lenses		2 weeks before surgery
Deductibles		At time of service
Medical Records Copying fee	$30.00	At time of service

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

Signature of Patient _____ **Date** _____

Minors and Dependent Patients

For all services rendered to minors and dependent patients, we will look to the parent or guardian accompanying the patient. In case of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth, and social security number.

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

Signature of Parent/Guardian _____ **Date** _____