Commonwealth Eye Care Associates Telephone: (804) 217-6363	***Dr. Andrew J. Michael, Dr. Shawn H. Hobbs, Dr. Joseph D. Iuorno, Dr. Tami A. Flowers, Dr. Meredith Diehl, Dr. Jonathan Noble, Dr. Drew Munro, Dr. Matthew Young, Dr. Vera Dham***

PATIENT REGISTRATION, CONSENT TO TREATMENT, AND PAYMENT AUTHORIZATION
PLEASE FILL OUT FORM COMPLETELY & PRINT CLEARLY

NAME____ BIRTH DATE_____________
LAST FIRST MI NICKNAME MONTH DAY YEAR

ADDRESS____
STREET CITY STATE ZIP

SEX: F M MARITAL STATUS Single Married Divorced Separated Widowed Other

RACE: Caucasian/ African American/ American Indian/ Asian Hispanic-Latino/ other ________________

ETHNICITY; American/ Mexican/Japanese/Chinese/Asian/European/Latino/ other_________________

PREFERRED LANGUAGE: __________________ PATIENT'S SSN ______-______-__________
EMAIL ____

HOME PHONE __________________WORK PHONE_________________CELL PHONE_________________

WHICH NUMBER DO YOU PREFER WE CALL DURING BUSINESS HOURS?_____________________

EMPLOYMENT STATUS: FT PT RETIRED ACTIVE DUTY

EMPLOYER_______________________________________OCCUPATION_______________________________

PERSON WHO REFERRED ME TO THIS PRACTICE ____

OPTOMETRIST _____________________________LOCATED AT ______________________________________

PRIMARY CARE PHYSICIAN ___________________________PHONE_________________________________

EMERGENCY CONTACT: _________________________RELATIONSHIP:_____________________________
PHONE: ________________________________ ALTERNATE/CELL PHONE: ___________________________

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL) OR DNR? YES or NO

<u>NAME OF INSURANCE COMPANY OR HEALTH BENEFIT PLAN:</u>
PRIMARY____ Policy Holder Name______________________
SECONDARY:____ Policy Holder Name______________________
TERTIARY:____ Policy Holder Name______________________
(Please provide your insurance cards to our receptionist)

POLICY HOLDER'S NAME (Spouse/Parent/Guardian) ____
POLICY HOLDER'S DATE OF BIRTH (Spouse/Parent/Guardian) ___________________________________
POLICY HOLDER'S SOCIAL SECURITY NUMBER (Spouse/Parent/Guardian)______________________

Due to privacy regulations, please indicate below anyone that you want to allow to inquire about your medical status.
***I authorize the following person(s) to communicate with your office regarding my care:**
Name/Relationship: _____________________________Phone Number: _____________ Your Initial __________

Name/Relationship: _____________________________Phone Number: _____________ Your Initial: _________

CONSENT: I do hereby voluntarily consent to examination and treatment by COMMONWEALTH EYE CARE ASSOCIATES (the "Practice") and to the rendering of such care and medical treatment as may be deemed necessary or appropriate by the physicians and other clinical personnel of the Practice. I further consent to and understand that my eyes will be dilated at some of my visits to your practice. I understand that my vision may be impaired after dilation and I may experience blurred vision for several hours after my visit.

2. **NO GUARANTEE:** I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me or otherwise implied regarding the results of my treatment or examination by this Practice.

3. **NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B AND HEPATITIS C BLOOD TESTING:** I understand that under state law (Virginia Code Section 32.1-45.1) health care providers are authorized to test patients for HIV antibodies, Hepatitis B and Hepatitis C whenever the health care provider or any person employed or under the direction or control of the health care provider is exposed to the body fluids of a patient in a manner which may transmit blood-borne diseases, human immunodeficiency virus (HIV), Hepatitis B and Hepatitis C. According to this law, I will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider or other person who may have been exposed. Positive tests results will also be disclosed to me and as medically necessary for my treatment or as required or permitted by law. I understand that I will be given an opportunity to have appropriate counseling in connection with such test results.

4. **RELEASE OF INFORMATION:** I authorize the Practice to use or disclose my health information (1) for treatment purposes, (2) in connection with payment or reimbursement for health care services or materials provided to me, or (3) for the purpose of carrying out Practice operations. Such disclosure may be made to any person, company or agency which is or may be responsible for all or a part of the charges for my treatment and/or examination, including but not limited to insurance companies, medical service companies, managed care organizations, workers compensation carriers, peer review organizations, government agencies or other responsible parties, all or part of my medical information and records in connection with payment for or establishing the medical necessity of my admission or treatment, or as may otherwise be required by law. I also authorize the release of such information to other treating or consulting physician(s) as who may be involved in my care. [**In connection with the use of disclosure of my medical information, I acknowledge that the Practice has provided me with a NOTICE OF INFORMATION PRACTICES ("NOTICE") that explains how it anticipates use and disclosure of my medical information and I have had an opportunity to review this Notice. I understand that the Practice reserves the right to change the privacy practices set forth in this notice, but if changes are made, will mail me a copy of such changes to my last address. I understand that I have the right to request how the Practice uses or discloses my medical information, but that the Practice is not required to agree to any requested restriction. If the Practice does agree to any requested restriction, I understand that it must abide by that agreement. I further understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice has already taken action in reliance on my consent previous to my revocation.**

SIGNATURE OF PATIENT/PATIENT REPRESENTIVE: X_______________________________________

Please note that we will email a copy of your records to you upon request.

5. **ASSIGNMENT OF BENEFITS:** In consideration of medical services to be rendered to me or at my request, I assign to the Practice to the extent necessary to satisfy any outstanding indebtedness, all sums payable to or on my behalf pursuant to any health benefit plan, policy of insurance (including, but not limited to, health, liability, uninsured motorist or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused the need for treatment.

6. **FINANCIAL RESPONSIBILITY:** In consideration of medical services to be rendered to me or at my request, I understand that I owe, and unconditionally agree and promise to pay, the Practice the full amount charged for these services. I specifically agree to pay for any services which are determined by any health benefit plan or insurance company not to be covered. I understand that any check for services that is returned for any reasons, will result in a fee of $20 which will be added to my account. I further understand that if my account is not paid within sixty (60) days, it may be declared in default and placed in the hands of a collections attorney. I agree to pay a fee of thirty-five percent (35%) of the unpaid balance on my patient account to cover attorney's fees should I default on my debt.

7. **MEDICARE PATIENTS ONLY:** I request payment of authorized Medicare, Medicaid and TRICARE (CHAMPUS) benefits, if any, for any services furnished to me by the Practice and hereby assign such benefits otherwise directly payable to me to the Practice. I authorize the Practice or physician(s) providing services to submit a claim for such services to Medicare, Medicaid or TRICARE (CHAMPUS) on my behalf. I authorize the Practice or any holder of medical and other information about me to release to Medicare, Medicaid, TRICARE (CHAMPUS) or its agents any information needed to determine these benefits. I understand that I am responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare, Medicaid or TRICARE (CHAMPUS).

8. **CONTENT OF FORM:** I have read the information provided in this form (or had such information read to me) carefully and in its entirety, have been given an opportunity to ask questions and have received satisfactory answers to my questions, if any. I understand the content of this form and agree to the terms contained herein. I certify that all information supplied by me as part of the patient registration process is correct.

________________________________ __________ **X** _____________________________________ ________________

Witness Date **Patient** **Date**

For any patient who is incapable of providing informed consent to medical treatment or assuming financial responsibility for payment of medical services, a legal representative of the patient must complete the following and sign on behalf of the patient. By my signature below, I certify that I am authorized by law to provide consent on behalf of the Patient.

________________________________ __________ ____ __________

Witness Date Patient Representative Date

____

Relationship to Patient

Acknowledgement of Receipt

I acknowledge that I have been informed of the Commonwealth Eye Care Associates Notice of Privacy Practices. (See Number 4 above)

Patient Signature: X____ Date_______________