RIVER'S BEND EYECARE

PATIENT HISTORY FORM

Appointment Date:

Patient's Name: _____ Birth Date: ____/____/____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

Email Address: _____ Cell Phone #: _____

Occupation: _____ Employer: _____ Work Phone #: _____

Medical Insurance: _____ Policy #: _____

Vision Insurance: □ VSP □ Eyemed/Blueview Vision □ Davis Vision □ Other _____

Responsible Party if different: _____ Relationship to Patient: _____

How did you find out about our office? _____ Date of last eye exam: _____

OCULAR HISTORY		
Do you wear glasses?	☐ No ☐ Yes	If yes, how old are your glasses?
Do you wear contact lenses?	☐ No ☐ Yes	What type? ☐ Soft ☐ Toric ☐ Multifocal ☐ Rigid
How often do you replace contacts?	☐ Daily ☐ 1 week ☐ 2 weeks ☐ 1 month ☐ 2 months ☐ Other	
Any surgeries or trauma to eyes?	☐ No ☐ Yes	If yes, give details.
Have you been diagnosed with any of the following eye conditions? **Check the box if "yes".**		
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Dry Eye ☐ Other		

MEDICAL HISTORY
Have you been diagnosed with any of the following health conditions? **Check the box if "yes".**
☐ Hypertension ☐ High Cholesterol ☐ Diabetes ☐ Other
List all medications:
Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones:
Are you currently pregnant and/or nursing? ☐ No ☐ Yes

FAMILY HISTORY Please note any family history of the following conditions, including relation to you (Siblings, Mother, Father, Grandparents, etc)
☐ Glaucoma _____ ☐ Macular Degeneration _____ ☐ Cataract _____ ☐ Retinal Detachment _____ ☐ Other _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "yes"**		
☐ Blurred Vision	☐ Flashes/Floaters	☐ Redness
☐ Loss of Vision	☐ Halos/Glare/Light Sensitivity	☐ Excess Tearing/Watering
☐ Loss of Side Vision	☐ Dryness	☐ Mucous Discharge
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Inflammation of the Eyelid
☐ Double Vision	☐ Burning	☐ Styes or Chalazion
☐ Tired Eyes	☐ Itching	☐ Other Concerns _____

RIVER'S BEND
EYECARE

Inderpreet K. Datta, OD
204 Johnson Creek Drive, Chester, VA 23836
Phone: (804) 530-3937
www.riversbendeye.com

Payment Policy

I understand that payment is expected at the time service is rendered. All balances are expected to be paid in full before materials are delivered.

Should my account be turned over to a collection agency, I agree to pay all costs incurred related to the collection process.

I understand that the insurance information provided is my responsibility and that if the insurance company does not pay a claim; I may be billed for those fees.

All materials should be picked up within thirty (30) days after notification of completion.

If my glasses/contact lenses are returned to stock, full payment will be required to reorder materials.

Returns and Remakes

If a patient is not satisfied with their lens or frame selection, Dr. Datta will have materials of the same value remade one time at no charge. This request must be made within thirty (30) days of completion. Any elected upgrades to the new frame or lenses will be at the patient's expense and will be due at the time the reorder is placed.

Some insurance plans have guidelines for material remakes and refunds which we are obligated to follow.

Deposits made on glasses are not refundable for materials that are not picked up within thirty (30) days of completion.

Unopened boxes of contact lenses can be exchanged if request is made sixty (60) days of order.

Contact Lens Services

Many insurance plans regard contact lenses as "cosmetic" therefore not covering services related to contact lenses, this amount may be due from you today.

Refractions:

Many medical plans (Medicare) do not pay for the service of "Refraction". This is the part of the exam that determines your prescription. This amount may be due from you today pending your insurance coverage.

Dr. Datta and staff thank you for taking the time to read and sign this form.

Social Security # of Patient _____ **Date of Birth _____**

Social Security # of Plan Holder _____ **Date of Birth _____**

Signature of Patient or Guardian _____Date _____

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Authorization for Release of Health Information

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information to carry out treatment, payment or health care operations.

As a patient of River's Bend Eyecare, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information for treatment or payment of claims.

You have the right to review our Notice of Privacy Practices before signing this consent form. The Notice of Privacy Practices describes possible uses and disclosures of your Personal Healthcare Information. You also have the right to request restrictions on how your Personal Healthcare Information shall be disclosed to carry out treatment and payment of claims, but the restrictions must be submitted in writing to our Practice Administrator. We, however, are not required to agree to those restrictions but are required to inform you of our decision before further treatment is administered.

It is completely your decision whether or not to sign this authorization form. Under this law, when your health information is disclosed as provided in this form, the recipient often has no legal duty to protect its confidentiality. However, if you sign this authorization you may revoke it at a later date. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. Again, if you choose to revoke this authorization, you must submit your request in writing to our Practice Administrator.

I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name _____ Date of Birth: _____

Signature _____ Date _____

If you are signing as a personal representative of the patient, please give your name and describe your relationship to the patient.

Print Name: _____ Relationship _____

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read or had explained to me River's Bend Eyecare's Notice of Privacy Practices.

A copy of River's Bend Eyecare's Notice of Privacy Practices was given to me if requested.

Patient Name _____

Signature _____

Date _____

Wellness Retinal Photos

I had the chance to read over the information regarding Wellness Retinal Photos. I understand there will be a charge of $39 unless the photos can be billed to my medical insurance.

☐ Yes, I would like Retinal Photos ☐ I would like to discuss with the doctor.