



SHADY GROVE OPHTHALMOLOGY™

-REGISTRATION FORM-

DATE: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ Gender: _____ Marital Status: _____ SSN _____

Address: _____ Apt#: _____

City/State/Zip: _____

Home #: _____ Cell #: _____ Work#: _____

Appointment Confirmation System: Circle Preferred Contact Method: Home / Cell / Work

Is it Ok to leave a Voice Mail? Y N **Text?** Y N **Email Address :** _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Authorized Person to discuss Medical information with: _____ Phone: _____

We would like to update your primary or referring doctor regarding your medical status, Please fill out this information:

Primary Care Physician _____ Primary Care Physician Phone _____

Referring Physician _____ Referring Physician Phone _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Address/City: _____

As a courtesy to you we are able to send prescriptions electronically to your pharmacy before the end of your visit.

INSURANCE INFORMATION (IF POLICY HOLDER IS DIFFERENT FROM PATIENT)

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Group #: _____ ID#: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Date of Birth: _____ SS#: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____ Relationship to Patient: _____

INFORMATION OF RESPONSIBLE PARTY (FOR MINORS)

Parent Name: _____ Date of Birth: _____ SS#: _____

Address _____

Home #: _____ Work #: _____ Employer: _____

Race: _____ Ethnicity: _____

HOW DID YOU HEAR ABOUT US:

Name of Friend: _____ Internet: _____

Doctor: _____ Doctors Phone _____

Other: _____

ACKNOWLEDGEMENT OF REFRACTION POLICY (GLASSES PRESCRIPTION)

Eye examinations have two portions, the medical eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams (Vision plans) or medical exams (medical insurance). *Most insurance plans including Medicare do not pay for refractions.* We do not accept Vision Plans. This will be up to the doctor and the patient during the exam.

Our refraction fee is \$60.00.

Patients or Guardian Signature: _____ **Date:** _____



Today's Date: _____

Medical History Form

Last Name: _____ **First Name:** _____ **DOB:** _____

Review of Systems:

Do you currently have any of the following problems: (Please check ALL that apply)

- | | | | | | |
|--------------------|-----|-------------------------|----------------------|------------------------|-----|
| Blurry Vision | ___ | Seizures | ___ | Seasonal Allergies | ___ |
| Sandy Sensation | ___ | Foreign body sensation | ___ | Ear Ache | ___ |
| Eye Pain | ___ | Contact lens discomfort | ___ | Jaw Pain | ___ |
| Excessive Tearing | ___ | Mucous in eyes | ___ | Weight loss | ___ |
| Redness | ___ | High Blood Pressure | ___ | Cough | ___ |
| White Flashes | ___ | Arthritis | ___ | Do you take Plaquenil? | ___ |
| Floater | ___ | Headaches | ___ | On Dialysis | ___ |
| Sensitive to Light | ___ | Scalp Tenderness | ___ | Atrial Fibrillation | ___ |
| Glare | ___ | Anxiety | ___ | Pacemaker | ___ |
| Loss of Vision | ___ | Depression | ___ | | |
| Stye | ___ | Diabetes ___ | Last A1C level _____ | | |
| Tired eyes | ___ | Other | _____ | | |

Medical History: **Are You Pregnant?** Yes No

What medical conditions do you have?

Major Surgeries:

Past Eye History:

Do you have...

List any EYE surgeries you have had in the past

- | | | | |
|--------------------------|-------|-------------------|-------------|
| ___ Cataract | _____ | Eye: right / left | When? _____ |
| ___ Glaucoma | _____ | Eye: right / left | When? _____ |
| ___ Macular degeneration | _____ | Eye: right / left | When? _____ |
| ___ Diabetic Retinopathy | | | |
| ___ Retinal detachment | | | |
| ___ Dry Eyes | | | |

Do you wear ___ Glasses ___ Contact Lenses

Family Eye History: (Please check ALL that apply)

- | | | | | |
|--------------|---------------|--------------------------|------------------------|-------------------|
| ___ Glaucoma | ___ Blindness | ___ Hypertension | ___ Retinal Detachment | ___ Heart Disease |
| ___ Cataract | ___ Diabetes | ___ Macular Degeneration | ___ Cancer | ___ Strabismus |

Social History:

Smoking Status:

Exercise:

Caffeine:

Alcohol:

Driving Status:

- | | | | | |
|-----------------------|-------------------------|-------------------------|-----------------------------|---------------------|
| ___ Current/Everyday | ___ Several times a day | ___ Several times a day | ___ 3 or more drinks/Daily | ___ Drives at Night |
| ___ Current/Some Days | ___ Once a day | ___ Once a day | ___ 1-2 drinks/Daily | ___ Drives in Day |
| ___ Former Smoker | ___ Few times a week | ___ Few times a week | ___ Less than 1 drink/daily | |
| ___ Never | ___ Few times a month | ___ Few times a month | ___ Occasionally | |
| | ___ Never | ___ Never | ___ None | |

Medications:

Eye Drops:

Allergic To ANY Medications:

FINANCIAL POLICIES:

REFRACTION-GLASSES PRESCRIPTION: Eye examinations have two portions, the medical eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams (Vision plans) or medical exams (medical insurance). Most insurance plans, including Medicare do not pay for refractions. We do not accept Vision plans.

Therefore, our **Refraction fee is \$60.00.**

HMO PLANS/REFERRALS: As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral to see a specialist, it is your responsibility to obtain the referral form from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered on that day. If you do not have your referral on the day of your visit you will have 5 business days to obtain one from your primary care. Once we get the referral form, we will reimburse you for charges made on that service date.

CO-PAYMENTS: Will be collected at the time of service. There will be a \$25 fee for returned checks.

MEDICARE: If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

MEDICAL INSURANCE: It is your responsibility as the patient/guarantor to provide us with your current medical insurance card. If it has changed or not active on the day of your visit you may be asked to reschedule or become financially responsible for the balance in full. We do offer financing options through Care Credit.

SELF PAY /NO INSURANCE: If you are the sole party responsible for all charges incurred, we ask that you make your payments at the time of service. If your treatment is extensive, or you require any type of surgical procedure including any refractive procedures, we offer financing options through Care Credit.

NO SHOW/LATE/CANCELLATION: If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency) so that we may open your reserved time for another patient. We request that you keep scheduled appointments and arrive on time.

No-Show for your appointment will result in a \$40 fee. If more than 15 minutes late, you may be asked to reschedule your appointment.

MVA AND OTHER FORMS: We will charge a \$25.00 fee for MVA forms to be filled outside of your appointment. Any other forms that require the doctor's signature and review will also be a \$25.00 fee. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment. A copy of your valid driver's license will be required.

REQUEST FOR MEDICAL RECORDS: Requests for copies of medical records must be made in writing or by filling out our Medical Records Release Form. Copies of medical records can be made for a fee of \$25.00.

Please be aware that we ask for at least 5 business days to release records.

WORKERS COMP: You will need to bring the following information: case number, address of the claim company, name, and contact phone number of the person assigned to the claim. If you do not have this information, you will be held accountable for exam cost and reimbursed if and when information is obtained.

REFRACTIVE LENS EXCHANGE, LASIK, PRK: This is a surgical procedure done after being evaluated and approved by the doctor. Appropriate to patients who want freedom from glasses and contacts. This is not covered by medical insurance. If you are unable to keep your surgical appointment, please let us know within 24 hours.

BILLING QUESTIONS AND PAYMENTS: Contact Carrie at our Billing Department for questions or concerns on bill related issues at (301) 762-0459.

I, _____ (PRINT NAME) have read and understood Shady Grove Ophthalmology's policies and have discussed any questions to their staff.

Patient Signature

Date*Modified 1/31/19*

Anthony O. Roberts, MD
9715 Medical Center Dr, Suite 502
Rockville, MD 20850

P: (301)279-0600 F: (301) 294-5322

www.ShadyGroveOphthalmology.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Anthony O. Roberts, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Anthony O. Roberts, M.D. office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review Notice of Privacy Practices prior to signing this consent. Anthony O. Roberts, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained at any time during your visit.

With my consent, Anthony O. Roberts, M.D. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment or other health care operation (TPO). Such as post operative telephone calls, insurance items, or any call pertaining to my clinical care.

With my consent, Anthony O. Roberts, M.D. may mail or fax to my home or other designated location any items that assist the office in carrying out treatment, payment or healthcare operation (TPO), such as patient statements.

By signing this form, I am consenting to Anthony O. Roberts, M.D. offices disclosure of my protected health information (PHI) to carry out treatment, payment, or other healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the office has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Anthony O. Roberts, M.D. may decline to provide treatment to me.

Print Name of Patient or Legal Representative

Signature of Patient or Legal Representative

Date

I have received a copy of the Patient Bill of Rights