LAWRENCE S. FRANK, MD / SEEMA A. GUPTA, MD

Patient Name:_____Date of Birth:_____Age:_____ Female □ Male □

If Patient is under 18, Please name Parent or Guardian responsible:_____

Address:_____City:_____State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____

Email Address:_____Pharmacy Name & Phone:_____

Occupation: _____ Full-Time Student? Y □ N □

Employer: _____ Business Phone#: _____

Patient's Marital Status _____ Patient's Social Security Number (Optional) _____-_____-_____

Spouse's Name: _____ Phone #: _____

Emergency Contact Name:_____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

How did you hear about our practice? □Insurance Plan □ Internet/Phonebook □ Family or Friend

□ Referred by Dr. _____ Phone #: _____

Other Languages: _____ □ Preferred language

INSURANCE INFORMATION

Primary Insurance:_____ Are you the **Primary Insurance Holder**? □ YES □ NO

Name of Insured (If not self) _____ Insurance Holder's Date of Birth _____ (Required)

Secondary Insurance: _____ Are you the **Primary Insurance Holder**? □ YES □ NO

Name of Insured (If not self) _____ Insurance Holder's Date of Birth _____ (Required)

Signature of Patient or Legal Guardian_____**Date**_____

Rockville Eye Physicians
Ophthalmologists - Eye Physicians and Surgeons ***WWW.REPEYE.COM***

Lawrence S. Frank, MD
Seema A. Gupta, MD

121 Congressional Lane, Suite 412
Rockville, MD 20852
Telephone (301) 770-4636
Facsimile (301) 770-7860

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____
Patient's Full Name

_____
Patient Signature (or Legal Guardian) Date

Authorization of Protected Health Information to Another Individual

Rockville Eye Physicians may disclose my protected health information to the listed individual:

_____
Name of Authorized Individual Relationship to Patient Phone #

_____
Patient Signature (or Legal Guardian) Date

Updated 6/2017

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Our Financial Policy

We participate with most major insurance plans for medical and surgical ophthalmology. **We do not participate with any vision plans (VSP, Davis Vision, FEP Blue Vision, etc.) for routine eye exams**. If you have a managed care plan that requires a referral, it must be present at the time of your appointment; otherwise the visit must be rescheduled.

It is the patient/parent/guardian's responsibility to:

- Bring all current insurance cards with ID to all visits.
- Provide our office with current information including address and phone numbers.
- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.

In accordance with your insurance contract you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will have to reschedule your appointment.
Any payment made by check that does not clear your bank will result in a $25.00 fee, which will be added to your account. Any outstanding balance in your account must be paid before your next appointment.
Any patient who does not show up a scheduled appointment or surgery without notice will be charged a cancellation fee of $25.00. Legitimate emergencies will be taken into consideration.

I have read and understand the above financial policy.

_____ _____
Print Patient's Name Date

_____
Patient's Signature (Legally Responsible Adult for Minor)

Updated 11/2015

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Refraction Service and Fee

A refraction is the process of determining your best corrected vision for eyeglasses. It is an essential part of an eye examination and is necessary in order to write a prescription for glasses. A refraction is **not** required at every visit; therefore, this form is only to acknowledge that you understand our policy.

A refraction is NOT covered by Medicare or most insurance plans. It is considered a "vision" service, not a "medical" service. Our fee for the refraction is $65.00. We will not file the charges for a refraction with a health insurance plan. You will be responsible for paying the $65 fee at the time of service **in addition to any copayment, coinsurance, or deductible** your insurance plan may require.

Once a refraction has been requested, and the exam has been performed by the physician, the patient will be responsible for the $65 fee. This charge will apply even if there are only minor or no adjustments made to your current eyeglass prescription. If you believe the prescription for your glasses provided by our practice is not accurate, we can re-check your prescription within 3 months of the date of the prescription at no charge. If it is more than 3 months, there will be a charge of $65.00 for re-checking your prescription since your eyes may have changed since the initial exam.

Precautions following Dilation

It may be necessary to dilate your eyes during your eye examination. Dilation may result in sensitivity to light and decrease your ability to see well for 3 hours or longer. We provide free disposable sunglasses. Patient should wear sunglasses and be cautious walking and using stairs. We recommend not driving or operating machinery until the effect on your vision has worn off.

Patient Acknowledgement Regarding Refraction Service, Fees and Dilation

I also accept full financial responsibility for the cost of a refraction and understand payment is due at time of service. I understand that the fee for refraction is separate from and in addition to any **copayment, coinsurance, or deductible I may have for the general office visit.**

I have been advised that I should not drive or operate machinery while my eyes are dilated because my vision and driving ability may be impaired. If I choose to drive or operate machinery while dilated, I accept full responsibility (financial and otherwise) for any adverse consequences.

I understand that dilation is necessary to diagnose and evaluate my eyes. I hereby consent to dilation at this and future visits.

I have read and understand the above information regarding refraction and dilation.

_____ _____
Patient's Name (Printed) Date

_____
Patient's Signature (Legally Responsible Adult for Minor)

Updated 11/2016

Name of Medication	Strength/Dose	How often taken/Route	Reason for taking
Example: Celebrex	*Example: (1) 100mg*	*Example: Twice daily, mouth*	*Example: Arthritis*

Are you allergic to any medications? ☐ YES ☐ NO LATEX gloves? ☐ YES ☐ NO Other allergies? ☐ YES ☐ NO
If YES, please list:

_____

Please list all major surgeries and approximate dates:

YOUR HEALTH HISTORY

Please Circle **YES or NO** and **Circle** specific problem **if YES**.

YES NO Diabetes
YES NO Thyroid Condition
YES NO Heart Condition
YES NO High Blood Pressure
YES NO High Cholesterol
YES NO Cancer / Leukemia
YES NO Asthma / Bronchitis / Emphysema
YES NO Difficulty Breathing / Chest Pain
YES NO Persistent Cough / Bloody Sputum
YES NO Stomach / Liver/ Intestinal Problems
YES NO Prostate / Ovarian or Uterus Problems
YES NO Hearing / Taste / Smell Problems
YES NO Arthritis / Lupus
YES NO Multiple Sclerosis
YES NO Night Sweats
YES NO Fever
YES NO Dizziness
YES NO Headaches / Migraines
YES NO Seasonal Allergies
YES NO Weight Loss / Poor Appetite
YES NO Smoke If yes, how much? _____
YES NO Drink Alcohol If yes, how much? _____

Other medical conditions: _____

FAMILY HISTORY

Please Circle YES or NO

YES NO Diabetes
YES NO Heart Disease
YES NO Cancer
YES NO Cataracts
YES NO Macular degeneration
YES NO Glaucoma
YES NO OTHER: _____

Do you wear Eyeglasses? YES NO
☐ for distance ☐ for reading
Contact lenses? YES NO
Have you had eye surgery? YES NO
If yes, please explain:

_____

Patient Name: _____

Patient Signature: _____ Date_____

You will be asked to update this information every year and to initial and date down below.

Updated on_____ Initials_____ Updated on_____ Initials_____
Updated on_____ Initials_____ Updated on_____ Initials_____