LAWRENCE S. FRANK, M.D. / SEEMA A. GUPTA, M.D. / LORENA R. SEPSAKOS, M.D.

Patient Name: _____ Date of Birth: _____ ☐ Female ☐ Male

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

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Preferred contact #: ☐ Home ☐ Cell ☐ Work

Email Address: _____

Occupation: _____

Patient's Marital Status: _____

Spouse's Name: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Primary Care Physician: _____ Phone #: _____

How did you hear about our practice? ☐ Insurance Plan ☐ Internet ☐ Family or Friend

☐ Referred by Dr. _____ Phone #: _____

Other Languages Spoken: _____ Preferred Language: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

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
Lorena R. Sepsakos, MD

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

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 non-medical routine eye exams**. **Any patient who would like to have a non-medical eye exam will be charged a fee of $210 at the time of your appointment.**
If you have a managed care plan that requires a referral from your primary care physician, 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 the following:

- All current insurance cards and photo ID.
- Referring physician name and a referral from your referring physician if provided.
- Any referrals from your primary care physician required by your insurance.
- Co-payments, coinsurance and deductibles, as required.
- Fee for a service not covered by insurance
- Current information including medications you are taking, your address and phone numbers.

In accordance with your insurance contract, you must be prepared to pay your co-pay, coinsurance, deductibles, and fee for a service not covered by insurance at each visit. If you do not make a payment at the time of the visit, your appointment will be rescheduled. Any outstanding balance in your account must be paid before your next appointment.
As a rule, you should contact your insurance payer before your visit to find out what is and is not covered under your plan and whether you will be responsible for any part of the payment.
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 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 06/21/21*

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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 6/2020

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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 $95.00. We will not file the charges for a refraction with a health insurance plan. You will be responsible for paying the $95 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 $95 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 $95.00 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 06/2023

HEALTH INFORMATION

MEDICATIONS

Please list medications you are currently taking:

ALLERGIES

Check all that apply:

- ☐ LATEX gloves
- ☐ Sulfa
- ☐ Penicillin
- ☐ Adhesive Tape
- ☐ Seasonal
- ☐ Other Drug Allergies:
  Please list:_____

SURGICAL HISTORY

Please list all major surgeries including eye surgeries and approximate dates:

YOUR HEALTH HISTORY

Check all that apply:

- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Diabetes ☐ Type1 ☐ Type2
- ☐ Dialysis
- ☐ Emphysema
- ☐ Grave's Disease
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hearing Loss
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Smoke:
  - ☐ Former
  - ☐ Light Tobacco User
  - ☐ Heavy Tobacco User
- ☐ Alcohol:
  - ☐ Occasional/Social
  - ☐ 1-2 Drinks/Day
  - ☐ 3-4 Drinks/Day
- ☐ Other:_____

Cancer:

- ☐ Breast
- ☐ Colon
- ☐ Leukemia
- ☐ Lung
- ☐ Prostate
- ☐ Skin
- ☐ Thyroid
- ☐ Other: _____

FAMILY HISTORY

- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Macular Degeneration
- ☐ Other:_____

Patient Name: _____

Patient Signature: _____Date_____