THIS IS NOT A "FILLABLE DOCUMENT"-PLEASE PRINT, COMPLETE AND RETURN THIS DOCUMENT TO THE OFFICE

MARYLAND VISION INSTITUTE, LLC * PHYSICIAN'S SURGERY CENTER
PATIENT REGISTRATION AND INFORMATION

Patient Information **Today's Date:** _____ **Account No.**_____
Last Name_____ First Name_____ M.I._____
Date of Birth _____/_____/_____ Age_____ Social Security #_____
Address _____
Apartment or Room_____City_____State_____Zip_____
Home# (___)_____Work# (___)_____Ext_____
Cell# (___)_____Email _____

(Please circle above preferred method of contact)

Sex (circle): Male Female Employer_____ Email: _____
Marital Status (circle): Married Single Widow(er) Divorced Separated
Race (check one): ___ American Indian ___ Asian ___Black/African American ___Native Hawaiian
___ Other Pacific Islander ___White ___Prefer not to answer
Ethnicity (check one): ___ Hispanic/Latino ___Not Hispanic ___Prefer not to answer
Preferred Language (check one): ___ English ___Spanish ___Other _____(list) ___Prefer not to answer

Referring Doctor _____ Office Phone #(___)_____
Address _____
Primary Care Physician_____ Office Phone #(___)_____
Pharmacy _____

Emergency Contact
Name_____ Relationship_____ Phone(___)_____
Do you give our office permission to discuss your medical information with family members? Yes No
If yes, please provide their name and phone number below.
Name: _____ Phone (_____) _____
Name: _____ Phone (_____) _____
May we leave personal medical information on your voice mail? Yes No
May we email personal medical information to you? Yes No
May we email updates, newsletters and general MVI information to you? Yes No

How did you hear about MVI? (circle) Ad Flyer Web Friend/Family Family/Referring Physician Event Self Referred

Insurance Information

Note - If you have a worker's compensation or auto claim, please also fill in your health insurance information

Section A- Vision Insurance
Insurance Company_____ Referral Required (circle) Yes No
ID #_____ Group_____
Insurance Subscriber_____ Date of Birth ____/____/____
Relationship to Patient_____ Social Security #_____
Subscriber Employer_____ Work # (___)_____

Section B- Health Insurance-Primary
Insurance Company_____ Referral Required (circle) Yes No
ID #_____ Group_____
Insurance Subscriber_____ Date of Birth ____/____/____
Relationship to Patient_____ Social Security #_____
Subscriber Employer_____ Work # (___)_____
Employer Address_____

Insurance Information continued

Section B- Health Insurance-Secondary

Do you have a secondary insurance? Yes No Insurance Company_____

ID #_____ Group_____

Insurance Subscriber_____ Date of Birth ___/___/___

Relationship to Patient_____ Social Security #_____

Subscriber Employer_____ Work # (___)_____

Employer Address_____

Note – For Automotive Accident claims - If you DO NOT have health insurance you will be responsible for the payment in full at the time of service.

Section D- Worker's Compensation Claim Information

Is this injury related to a work accident? Yes No If yes, Date of Accident___/___/___

Compensation Insurance_____Claim #_____

Claims Address_____ Phone # (___)_____

Claim Adjuster_____ Employer's Name_____

I, the below signed, certify that the above information is true and correct to the best of my knowledge.

Signature of Patient/Responsible Party:_____ Date: _____

Cancellation Policy -Maryland Vision Institute, LLC aka "the clinic" and Physician's Surgery Center aka "ASC" requires 24 hours-notice when canceling any appointment or procedure. After three charges/violations you may be subject to termination from the clinic and/or the ASC.

- I understand that I will be liable for a charge of $40.00 if I fail to give 24 hours-notice to cancel my appointment with the clinic. I understand that I will be liable for a charge of $100.00 if I fail to give notice to cancel my procedure with the ASC.

Return Check Policy

A $35 processing fee will be charged for checks returned by the bank for non-sufficient funds (NSF checks). Any penalties assessed on a patient's returned check will be charged to the patient's account.

- I understand the I will be responsible for returned check penalties and fees.

Vision Services Notification

Maryland Vision Institute, LLC reserves the right to perform services necessary for examination and treatment at the discretion of the physician. All non-covered fees will require payment at time of service. Refraction fees and contact lens fitting fees range from $30.00 to $200.00.

- I understand that I will be liable for non-covered fees for services on the day of service.

Often my eye doctor will find it necessary to dilate my pupils during my exam. Dilating drops frequently blur vision for some length of time and may make bright lights bothersome.

- I understand that due to this, driving may be difficult and have made appropriate arrangements. I hereby authorize my doctor and/or his/her assistant to administer dilating eye drops, since dilation may be necessary to diagnose my ocular medical issues.

I, the below signed, understand and agree to the terms of the Cancellation Policy, Return Check Policy and Vision Services Notification.

Signature of Patient/Responsible Party:_____Date: _____

Consent for Treatment

I hereby authorize Maryland Vision Institute, LLC, its employed providers and personnel, to perform services necessary evaluate, test and treat the above named patient at the discretion of the provider.

Signature of Patient/Responsible Party:_____Date: _____

MARYLAND VISION INSTITUTE, LLC
AUTHORIZATION/ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I _____ (Print Name) hereby authorize benefits to be assigned to Maryland Vision Institute, LLC, ("Provider"), for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company due upon receipt of invoice or statement from Provider, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at 220 Champion Drive, Suite 100, Hagerstown, MD 21740, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

If I am a Medicare or Medigap Benefit Participant I hereby authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers and/or Medigap insurance carrier, any information needed for this or related Medicare claim. I request MVI bill claims directly to Medicare and/or Medigap and for payments to be received directly by MVI. Medigap patients may receive the following message on their Explanation of Benefits: "Because you are assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days." Section 4801 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medigap benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges, due upon receipt of invoice or statement from Provider, of any and all appeals or request for information. I agree that should the account be considered "bad debt" or "uncollectable" or referred to an attorney or outside agency for collection processing, a 35% assessment of the full balance aka "collection fee" will be added to the account and become the full responsibility of the guarantor. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Guarantor Date

_____
Witness

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Maryland Vision Institute, LLC, ("MVI") creates and maintains health records describing my health history. I understand that MVI may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payors can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to MVI's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of MVI. In addition, I acknowledge that I received on the date indicated below a copy of MVI's Notice of Privacy Practices, which describes the obligations of MVI regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that MVI reserves the right to change its notice and practices. If MVI changes the notice, I can obtain a revised copy by asking the chief operating officer of MVI. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that MVI is not required to agree to the restrictions requested**, except that MVI must grant a request to restrict disclosure of my health information for payment or health care operations purposes if the disclosure is to a health plan and the health information relates solely to a health care item or service for which MVI has been paid out of pocket by me in full.** If MVI does agree to **any additional** restrictions, MVI must comply with such restrictions.

_____ I request the following restrictions to the use or disclosure of my health information.

_____

_____

EFFECTIVE DATE OF NOTICE: November 10, 2017

Signature of patient or patient's representative: _____

Date:_____

OR

Printed name of patient's representative:_____

Relationship to patient:_____

For Office Use Only:

Routine vs. Medical Eye Exams

The specifics of medical insurance can be confusing, and vision coverage is no exception. Insurance companies usually categorize visits to your eye doctor as either "routine" or "medical". This has little to do with the steps it takes to perform a full eye exam. A "routine" vision exam often contains the same elements as a "medical" eye exam. Also, the type of eye doctor you see does not determine if the examination is termed routine or medical, and either an optometrist or an ophthalmologist can perform the exam.

The reason for being seen and the results of the examination often determine whether insurance will classify the exam as routine or medical. The difference is determined by the reason for the visit, such as symptoms and complaints, and also the patient's diagnosis. Insurance companies often look at both when determining payment. The routine vision exam usually produces a final diagnosis, such as "nearsightedness" or "astigmatism", while the medical eye exam produces a diagnosis such as "conjunctivitis" or "cataract."

Depending on your policy, your medical insurance may cover a medical eye problem, but not pay for the exam if it is a "routine" eye exam. Other policies contain vision plans that provide coverage for glasses and contact lenses or at least give you some type of discount on the doctor's usual and customary fees. Many times, people with medical insurance have a separate rider policy to cover routine eye exams. To complicate matters more, some medical insurance will cover one routine eye exam every two years in addition to covering eye exams that are for a medical eye problem. And the co-pay for each type of exam may be different!

Here is an example of how both may work in real life:

You've decided that it is time for an eye exam because your glasses are falling apart, and you remember that you chose a health plan with routine vision coverage because you and your family members wear glasses. You first schedule a visit with one of our doctors, then arrive at your appointment where our office authorizes your benefit, and we proceed with the examination. At the end of the exam, your doctor informs you that in addition to a minor prescription change, the examination reveals signs that you may have glaucoma. He or she instructs you to return in one week for additional tests. Because at the end of that exam you are considered a potential glaucoma patient, your medical insurance may cover the exam and additional tests for a medical diagnosis of "glaucoma suspect". When time comes for your examination next year, it is possible that you could use your medical insurance to cover your examination, because this year it was determined that you could be at risk for developing glaucoma. You also may have expected a co-insurance (co-pay) of $20 that your plan requires for a routine eye exam, but end up paying a bit more or even less, if your co-insurance for a medical exam is different.

It is to your benefit to be aware of possible deductibles and co-pays that are a part of your plan. Your insurance plan may cover routine vision care, but you might end up paying for it anyway if your deductible has not yet been met. Please check with your benefits coordinator or by calling the customer service number provided on your card or policy for the details or your benefits. Your insurer is the best resource for your coverage questions and as a friendly reminder; always to be sure to get that information in writing.

Maryland Vision Institute is currently participating with the following vision plans:

EyeMed (includes Blue View Vision, Aetna Vision, Humana Vision and UniView Vision)
VSP (includes Metlife Vision and Cigna Vision)
American Benefit Corp.
CareFirst State of Maryland Employees (***not through Davis Vision***)
United HealthCare State of Maryland Employees (***not through Spectera***)
Lions Club with an approval letter

Please do not hesitate to ask one of our associates for further guidance or assistance.

MARYLAND VISION INSTITUTE, LLC
PATIENT HEALTH HISTORY AND INVENTORY
TEL 301-791-0888 FAX 301-791-3611

↑Visit Date _____ ↑Referred By _____ ↑Referral Phone _____ ↑Date of Birth _____ Male or Female (circle one)

↑Patient Name _____ ↑Primary Care Physician _____ ↑PCP Phone _____

↑Address _____ ↑Home Phone _____

↑City, State _____ ↑Zip _____ ↑Cell Phone _____

↑E-Mail Address _____

MEDICAL HISTORY

Medications

❑ None Taken or *List Below*

Name	Dosage	Frequency	Reason for

EYE Medications

❑ None Taken or *List Below*

Name	Dosage	Frequency	Reason for

Allergies

❑ None Known ❑ Latex

Drugs: _____

Food: _____

Eye History

Wear **Glasses** for (circle all that apply)? Nearsightedness Farsightedness Astigmatism Reading

Wear **Contacts** for (circle all that apply)? Nearsightedness Farsightedness Astigmatism Reading

❑ Glaucoma ❑ Lazy Eye ❑ Injury ❑ Macular Degeneration ❑ Cataract

List Others Below

Eye Surgery, Event or Disease	R eye	L eye	Date

Illnesses

❑ Diabetes ❑ Heart Disease ❑ Asthma ❑ High Blood Pressure ❑ Emphysema ❑ Stroke
❑ Cancer ❑ Arthritis ❑ COPD ❑ High Cholesterol ❑ CHF ❑ Sleep Apnea (C-Pap machine?)
❑ None or *List Others*

_____

_____

Surgery

❑ Tonsils ❑ Appendectomy ❑ Heart ❑ Gallbladder ❑ None or *List Others*

_____

_____

Family History			Relationship to Patient				Relationship to Patient
	Y	**N**	**M**other **F**ather **S**ibling **G**randparent		**Y**	**N**	**M**other **F**ather **S**ibling **G**randparent
Blindness				Heart Disease			
Glaucoma				High B/P			
Arthritis				Kidney Disease			
Cancer				Lupus			
Diabetes				Stroke			

Review of Systems	**Y**	**N**	**If YES, Please Explain**
General / Constitutional (fever, weight loss, obesity, etc)			
Integumentary / Skin (rashes, growths, hair loss, etc)			
Ears (hearing loss, drainage, etc)			
Neck (swollen glands, thyroid, etc)			
Respiratory (congestion, wheezing, COPD, etc)			
Cardiovascular (high B/P, racing pulse, etc)			
Gastrointestinal (stomach upset, diarrhea, constipation, etc)			
GenitoUrinary (painful or frequent urination, impotence, etc)			
MusculoSkeletal (joint pain, stiffness, swelling, cramps, etc)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc)			
Hemato-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia, etc)			

Do you drink alcohol? If Yes: ❑ occasionally ❑ 1/day ❑ 2-3/day ❑ 4+/day
Do you smoke? If Yes: ❑ occasionally ❑ ½ pack/day ❑ 1 pack/day ❑ 1+packs/day

Current Occupation: _____

Patient Signature: _____

MARYLAND VISION INSTITUTE, LLC
VISION AND LIFESTYLE QUESTIONNAIRE
TEL 301-791-0888 FAX 301-791-3611

Envision Your World More Clearly

Name: _____ Date: _____

Do you currently wear glasses or contacts? Yes: _____ No: _____

If yes, for what purpose? Far Distance _____ Near/Reading_____ Intermediate/Computer_____

If you wear contacts, are they soft or gas permeable (hard) lenses? _____

Have you ever considered LASIK surgery? Yes: _____ No: _____

Check the following activities you do on a regular basis:

Read	**Shop**	**Play a Musical Instrument**	**Dine In Restaurant**
Read Medicine Bottles	**Use handheld device (Iphone, Smart Phone, Blackberry, PDA)**	**Bicycle**	**Play Cards**
Needlepoint/Sew	**Play Tennis**	**Use the Computer**	**Golf**
Participate in Water Sports	**Hunt or Fish**	**Attend Concerts/plays/movies**	**Paperwork/Writing**
Drive-Daytime	**Paint/Draw**	**Cook**	**Photography**
Drive-Nighttime	**Watch Spectator Sports**	**Travel**	**Play Contact Sports (football, basketball etc…)**

Please list any additional occupational, recreational or other activities you currently engage in that are not listed above. _____

_____

What is your occupation? _____

Are you currently enlisted or planning on enlisting in the military or law enforcement? Yes___ No___

How old is your current glasses prescription? _____

Are you pregnant or planning to become pregnant? _____

How did you learn about us? _____