WELCOME!

Date: ______________ Acct#: ______________________

Patient Registration Information

Patient Name: ____ Sex: M F Age: ____________

(First) (M) (Last)

Birthdate: ____________________________ Patient SS#: __________________________________

Home Address: ____

(Street) (Apt. #)

____

(City) (State) (Zip)

Home Phone: _______________________Work Phone: _________________Cell Phone: ________________

May we leave a message if unable to reach you? (may contain personal information): ___YES ___NO

Email Address: ____

Employer: _________________________________ Occupation: ___________________________________

Spouse's Name: ___________________________ Phone: ____

Emergency Contact: ________________________________Phone:________________________________

Referring Physician: ____ Phone: ___________________________

Primary Care Physician: ______________________________________ Phone: ___________________________

Insurance Information

	Primary Insurance	Secondary Insurance
Ins. Co. Name:	____________________________	____________________________
Ins. Co. Address:	____________________________	____________________________
Ins. Co. Phone:	____________________________	____________________________
Group #:	____________________________	____________________________
ID #:	____________________________	____________________________
Name of Policyholder:	____________________________	____________________________
Policyholder's DOB:	____________________________	____________________________
Policyholder's SS#:	____________________________	____________________________
Relationship to Patient:	____________________________	____________________________
Employer:	____________________________	____________________________

*****OVER PLEASE*****

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (SPOUSE, PARENT OR LEGAL GUARDIAN)
(If other than patient)

Name: ______________________________ SS#: ______________________ DOB: __________

Relationship to Patient: __________________ Driver's License: ____________________________

Billing Address: ____
(Street) (Apt)

____
(City) (State) (Zip)

Home Phone: ___________________ Work #: __________________Cell #: _________________

ASSIGNMENT OF BENEFITS

I request payment of authorized Medicare and/or Insurance carrier benefits be made on my behalf to Capital Eye Care for any service furnished to me by Capital Eye Care's physicians. I authorize my physician to release to Medicare and/or my Insurance carrier(s) any information needed to determine these benefits or the benefits payable for related services. **I agree to provide all referrals as required by my insurance carrier(s)**. I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days as a result of incorrect insurance information provided by me (not errors on part of provider claim submission) will become my financial responsibility. I understand any unpaid balances and non-covered services are my financial responsibility. Capital Eye Care reserves the right to charge a $25.00 service fee for any unpaid balances including co-pays and deductibles that are due at the time of service. I understand I will be charged a missed appointment fee of $50.00 per visit should I fail to provide 24 hours notice of cancellations or rescheduling. I also understand I will be charged a $35.00 fee for any returned check. Should my account be turned over to a collections agency, I understand that I will be charged for all collection and or attorney and court fees.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: ____ *Date*: ______________________

Signature: ____ *Date*: ______________________

Signature: ____ *Date*: ______________________

Signature: ____ *Date*: ______________________

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.
- Authorize third party to verify insurance benefits and eligibility.

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 of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy 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 operations. 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.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: ____ *Date*: ______________________

6720A ROCKLEDGE DRIVE, SUITE 200
BETHESDA, MD 20817
PHONE: (301) 493-9600
FAX: (301) 493-9235
CHAMPLAINOPHTHALMOLOGY.COM

Champlain Ophthalmology

James M. Heltzer, M.D. • Omar Chaudhary, M.D.
Julia F. Malalis, M.D.

CATARACT & IMPLANT SURGERY
CORNEA & EXTERNAL DISEASE
GLAUCOMA SURGERY & MANAGEMENT
OCULAR IMMUNOLOGY & UVEITIS

Name: ______________________________ **Date of Birth:** __________ **Today's Date:** __________

If new patient, how did you hear about our practice? ______________________________

MEDICAL HISTORY QUESTIONNAIRE

What is the purpose of your visit today? ______________________________

List **Medical Conditions**, surgeries, or injuries with dates:

____
____
____
____
____

List all **Medications** (include eye drops):

____
____
____
____
____

Medication Allergies: ______________________________

Family Medical History (if yes, please include relationship):

Blindness	__________	Heart Disease	__________
Glaucoma	__________	Arthritis	__________
Macular Degeneration	__________	Auto-immune	__________
Retina	__________	Cancer	__________
Cataract	__________	Diabetes	__________
Other	__________		

Social History: Occupation: __________

Hobbies: __________

Alcohol: YES NO   Smoking: YES NO

Drugs: YES NO

Have you fallen in the past year? YES NO

Flu vaccine this year? YES NO

Pneumococcal vaccine (age>65)? YES NO

Do you wear glasses? (Indicate if they are for reading, distance, or both): ______________________________

Do you wear contacts? (indicate what type and how often): ______________________________

Have you had LASIK, PRK, or other refractive surgery? (Indicate where and when): ______________________________

Review of Systems: Please circle if you have any issues with any of the following:

Eyes:

Loss of Vision	Blurred Vision
Double Vision	Fluctuating Vision
Dryness	Tearing
Sandy/Gritty	Red eye
Crusty lashes	Discharge
Eye pain	Itching
Lazy Eye	Strabismus
Floaters	Flashes
Lid swelling	Glare at night

Other:

Diabetes	Thyroid issues
Environmental Allergies	Heart Disease
Runny nose/Sore throat	Hypertension
Breathing/Asthma	Rapid Heart Rate
Migraines	Sleep Apnea
Muscle/Joint Pain	Stomach Issues
Hearing difficulties	Dry Mouth
Stroke/Mental Status	Dizziness
Herpes	HIV

Champlain Ophthalmology
James M. Heltzer, M.D.
Omar R. Chaudhary, M.D.
Julia F. Malalis, M.D.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

______________________________ Patient Name (Please Print)

______________________________ Guardian or Authorized Party Name

______________________________ Date of Birth

I authorize the use and disclosure of my health information as described below:

- ☐ Records relating to treatment dates from: ____________ to: __________
- ☐ Records for all care at this facility, or by Doctor____________________
- ☐ I give my healthcare provider permission to discuss protected health information with ______________________(Name of Individual)

Information to be released:

☐ from ☐ to

______________________________ Name

______________________________ Address

____

______________________________ Phone

______________________________ Fax

☐ from ☐ to

Capital Eye Care, LLC.
Champlain Ophthalmology

6720A Rockledge Drive Suite 200
Bethesda, MD 20817
T: 301-493-9600 F: 301-493-9235

Form in which records are to be released:

- ☐ Paper Copies
- ☐ Flash Drive ($35 upfront charge)
- ☐ Mail
- ☐ Fax
- ☐ Pick up

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage. I understand that uses and disclosures already made based upon my original permission cannot be taken back. **I understand that the medical records to be released may contain information related to HIV status, AIDS, Sexually Transmitted Diseases, alcohol, or mental health services, and I hereby authorize the release of the information.** To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in a year from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproducing and forwarding of medical records. Black and White copies of last 4 visits free, if more is necessary, a preparation fee of $22.88, plus $0.76 per page, plus postage will be charged.

I understand that Capital Eye Care, LLC, Champlain Ophthalmology may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

______________________________ **Signature of Patient or Guardian**

______________________________ **Date**

A fax copy or photocopy of this consent shall be as valid as original. If this authorization is signed by a patient's personal representative, the representative authority is based on ______________________.
(Parent, Law, Court order, POA, etc.)

For office use only:
Physician Authorization: ____________________ Date Sent: __________ By: __________________

JAMES M. HELTZER, M.D.
OMAR CHAUDHARY, M.D.
JULIA MALALIS, M.D.

Refraction and Contact Lens Policy

Refraction Services

A refraction is the process of determining your prescription for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses. In order to get an accurate measurement, refraction must be done prior to your eyes getting dilated.

Medicare and many medical insurance plans do not cover refractive services. We charge separately for this refractive service if it is not covered. Our office fee for refraction is **$75**. This fee is collected on the day of service. If your plan does cover refractive services, we will reimburse you accordingly.

Contact Lens Evaluation

In order to write a prescription for contact lenses, you must have a contact lens evaluation. The charge for a contact lens evaluation ranges from **$100-$200** depending on the complexity of the process. Please ask us before your evaluation if you have concerns. We will be as specific as possible, but please understand we cannot always predict the complexity of the fitting.

If you have any questions regarding your insurance coverage, please do not hesitate to ask. We will do our best to assist you.

Yes, I would like to have refractive services.

Yes, I would like to have a contact lens evaluation.
Please initial after you receive a copy of your contact lens prescription _____

No, I would like to avoid refractive services.

Patient Name: ______________________________________

Signature: ______________________________________

Date: ______________________________________