EYEONE
RETINA CARE OF VIRGINIA

PATIENT INFORMATION (PLEASE PRINT) **REVISED 10/2024**

(NAME) LAST FIRST MI	DATE OF BIRTH	MARITAL STATUS SINGLE ☐ WIDOWED ☐ MARRIED ☐ OTHER ☐	SEX
STREET ADDRESS	CITY, STATE & ZIP CODE	HOME PHONE #	
MAILING ADDRESS	CITY, STATE & ZIP CODE	CELL PHONE #	
SOCIAL SECURITY #	☐ DISABLED ☐ RETIRED	EMPLOYER PHONE #	
RACE ☐ AFRICAN AMERICAN ☐ WHITE ☐ HISPANIC ☐ ASIAN ☐ KOREAN ☐ MULTIRACIAL ☐ DECLINE TO SPECIFY ☐ OTHER	LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ DEAF ☐ ARABIC ☐ KOREAN ☐ RUSSIAN ☐ DECLINE TO SPECIFY ☐ OTHER	ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ OTHER ☐ UNKNOWN ☐ DECLINE TO SPECIFY	
EMAIL	PRIMARY CARE PRACTITIONER		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #

INSURANCE INFORMATION

CARRIER	ID #

IF POLICY HOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE

POLICY HOLDER ____ MALE ☐ FEMALE ☐
SOCIAL SECURITY # ____
DATE OF BIRTH ____________________
EMPLOYER ____

IF PATIENT IS A MINOR (GUARANTOR INFORMATION)

LAST FIRST MI	DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS, CITY, STATE, & ZIP CODE		HOME PHONE #
EMPLOYER		WORK PHONE #

EyeOne / RetinaCare of Virginia

Patient Name ________________________ Date of Birth____/ ____ /____Date ________

Medications (if unable to complete staff will assist you)
(Attach list or list any medications that you now take.)

Eye Medications	**Other Medications**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Past Eye History – Have you ever experienced any of these eye conditions? Please circle all that apply.

Cataract

Cornea/Conjunctiva problem

Glaucoma

Refractive Surgery/LASIK

Neurological eye problem

Plastic Surgery around eyes

Retina: Tears Detachment

Eye Turning In or Out

Family History Please circle all condition(s) that occur in your family.

	RELATIONSHIP
Blindness	__________________
Cataracts	__________________
Glaucoma	__________________
Macular Degeneration	__________________
Retinal Disorders	__________________
High Blood Pressure	__________________
Diabetes	__________________
Heart Disease	__________________

Allergies ☐ NONE

List Allergies	**Reaction (Ex: Rash)**
__________________	__________________
__________________	__________________
__________________	__________________
__________________	__________________
__________________	__________________
__________________	__________________
__________________	__________________

Medical History
List any medical conditions for which you have been treated:

____
____
____
____
____
____
____
____
____
____
____

Surgical History
List surgery and date of surgery.

____
____
____

Social History
Are you a:

__ Current every day smoker
__ Current some day smoker
__ Former smoker
__ Smoker, current status unknown
__ Never smoker
__ Unknown if ever smoked

Alcohol use? __ Yes __ No __ Formerly

Blood Sugar (If known)

Blood Sugar ________ A1C ________
Date Taken ________

Tech Review _______Date_______ Tech Review _______Date_______

Additional Insurance Information

Insurance Name ______________________________

Insurance Phone # ______________________________

Member ID # ______________________________

Name of Vision Coverage (if known) ______________________________

Group # ______________________________

Subscriber Name ______________________________

Subscriber SSN ______________________________

Subscriber DOB ______________________________

General Consent for Treatment

The Practice: EyeOne, P.L.C., RetinaCare of Virginia

Patient Name: ______________________________________ DOB: _____/_____ /______

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize and direct the practitioners and professional staff to provide medical treatment to me, or the above named patient. I agree to examination, evaluation, treatment, diagnostic tests, procedures, and administration/injection of pharmaceuticals. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct the Practice and my attending practitioner to release such medical and demographic information as necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors. I authorize my employer to release all information regarding employment and salary verification. I authorize my insurance company to release all information regarding my benefits.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT: I hereby authorize and direct my insurance carrier and/or health care plan to make payment to the Practice and hereby assign to the Practice any and all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by the Practice. I acknowledge that it is my responsibility to notify the Practice of change in healthcare benefits or to obtain pre-certification for services. I understand that I am financially responsible to the Practice for all charges (regardless of insurance determination) including court cost, judgment cost, 25% collection costs, reasonable attorney fees, interest on past due balances, return checks, return check fees, and those charges not paid by insurers or health care plans incurred by me or in my behalf or the above named person. I understand I will receive a separate bill from my attending practitioner, emergency department, radiologist, anesthesiologist and hospital. Missed or cancelled appointments without 24 hour prior notification may be charged a missed appointment fee.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our privacy practices. I acknowledge that such Notice of Privacy Practices is displayed in the office or is available at www.eyeoneva.com or will be provided to me in print, upon requested and it is my responsibility to read this Privacy Notice if I desire. The Practice reserves the right to change our privacy practices as deemed necessary and our responsibility to publish the changes accordingly.

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) brought into the office or hospital is my responsibility and the Practice shall not be liable for loss or damage to any personal property.

CONFIDENTIAL TESTING: I understand that I have a responsibility to keep myself and others safe from HIV infection and other diseases therefore I consent to confidential testing as ordered by the Medical Director. I understand that the results will be documented in my medical chart. As long as this consent is in force the practice may require me to submit to tests without asking me to sign another consent form.

RIGHT TO REVOKE: My consent shall remain in effect until revoked in writing. I understand that I have the right to revoke this General Consent for Treatment by providing written notice to EyeOne, P.L.C, 17 North Medical Park Drive, Fishersville, VA 22939 Attention: Practice Manager. It is understood that treatment will be denied if this General Consent for Treatment is not signed or revoked.

Print Patient Name: ____ Date: ___________________________

Signature ____

(Patient of person authorized to consent or as Guardian/Guarantor)

Printed Name of authorized person: _______________________________Relationship: ________________

NOTICE OF PRIVACY PRACTICE

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- Public health reporting and oversight activities
- Judicial, administrative, or law enforcement proceedings
- Complying with workers' compensation laws
- Communicating with your family or caregivers
- Sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.

We understand the importance of privacy and confidentiality and are committed to taking the steps necessary to safeguard any medical or other individually identifiable health information that is created by or provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of protected health information ("PHI"); (ii) provide notice of our legal duties and privacy practices with respect to protected health information; (iii) abide by the terms of our Notice of Privacy Practices currently in effect; and (iv) notify affected individuals following a breach of unsecured PHI. This Notice describes how we may use and disclose your PHI. It also outlines your rights and our legal obligations with respect to this PHI. We will never market or sell personal information.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff. This notice applies to each of these individuals, entities, sites and locations. In addition, these individuals, entities, sites, and locations may share PHI with each other for the treatment, payment, and health care operation purposes described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number, information relating to your medical history, your insurance information and coverage, information concerning your doctor, nurse, or other medical providers and create a medical record for you. This medical record is the property of our ophthalmic practice, but the information in the medical record belongs to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care," such as your primary care provider, a referring physician, your other doctors, your health plan, and your close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

The law permits us to use and disclose personal and identifiable health information about you for the following purposes:

- Treatment. We may use your PHI in order to provide your medical care. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes. We may disclose information to others who are involved in providing your care. We will never share any substance abuse treatment records without your written permission.
- Payment. We may use and disclose your PHI to bill for our services and to collect payment from you or your insurance company.
- Health Care Operations. We may use and disclose your PHI for the general operation of our business.
- Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law.
- Public Health. We may disclose your PHI to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability. We may also use and disclose your PHI in order to notify persons who may have been exposed to a disease or who are at risk of contracting or spreading a disease.
- Health Oversight Activities: As required or authorized by law, we may disclose PHI to a public health authority or other government authority authorized by law to receive reports of child, elder, or dependent abuse or neglect or domestic violence, the Food and Drug Administration for activities such as adverse events, product defects or problems, or replacements; or to conduct post-marketing surveillance. We may disclose your PHI to health oversight agencies as authorized or required by law for health oversight activities such as audits, investigations, inspections, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions.
- Judicial and Administrative Proceedings. We may disclose your PHI in the course of administrative or judicial proceedings as required by law.
- Organ Donation. As authorized by law, we may disclose your PHI to organ procurement organizations, transplant centers, and eye or tissue banks.
- Worker's Compensation. We may disclose your PHI as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.
- Employers. We may disclose your PHI to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.
- Armed Forces. If you are a member of the Armed Forces, we may disclose your PHI for activities deemed necessary by military command authorities. We also may disclose health information about foreign military personnel to their appropriate foreign military authority.

- Correctional Institutions. If you are an inmate, we may release your PHI to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health, or safety, or the health or safety of others.
- National Security. We may disclose your PHI for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.
- Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully, such as by providing billing services. We may disclose your PHI to these business associates so that they can perform the tasks that we hire them to do and require them to protect the confidentiality of your PHI.
- Notification and Communication with Family. We may disclose your PHI to notify persons responsible for your care about your location, general condition, or death. We may disclose information to public or private entities authorized to coordinate such notifications for disaster relief purposes. We may also disclose your PHI to someone who is involved with your care or helps pay for your care. Generally, we will obtain your oral agreement before using or disclosing health information in these ways. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.
- Facility Directories. We may use your PHI to maintain a directory of individuals in our facility unless you object.
- Change of Ownership. In the event that this medical practice is sold or merged with another organization, your medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
- Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. If you are not home, we may leave this information in a telephone message, or a message left with the person answering the phone. We do not need your authorization to send you reminders or information about appointments, treatment, or medication that you are currently prescribed, even if we receive compensation from a third party for doing so, as long as the compensation only covers the costs reasonably related to making the communication.

OTHER USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

We are required to obtain written authorization from you for any uses and disclosures of PHI other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

To exercise any of your rights listed below, please contact our Privacy Officer in writing at the address listed below and include the details necessary for us to consider your request.

Restriction Requests. You have the right to ask for restrictions on certain uses and disclosures of PHI, including disclosure made to persons assisting with your care or payment for your care. We will consider your requests and notify you of the outcome but are not required to accept such requests. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Amend or Supplement. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information within 60 days. When making a request for amendment, you must state the reason for making such a request. Under certain circumstances, we may deny your request, such as when we do not have the information, the information was not created by us (unless the person or entity that created it is no longer available to make the amendment), you would not be permitted to inspect and copy the information, or the information is accurate and complete. If we deny your request, we will tell you why. You may submit a written statement of your disagreement with that decision. We may then prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Breach Notification. In the case of a breach of unsecured PHI, you have the right to be notified, as provided by law. If you have given us a current email address, we may use it to communicate information related to the breach. In some circumstances our Business Associate may provide the notification. We may also provide notification by other methods as appropriate. [Only use email if you are certain, it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "retinaldiseasedocs.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

Copy of Notice. You have the right to a copy of this notice in paper form, even if you agreed to receive notice electronically. You may ask us for a copy at any time.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for all PHI we maintain and any we may receive in the future. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/CONTACT INFORMATION

If you feel that your privacy protections have been violated by our office, you have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201 calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at EyeOne, Attn: Compliance Officer, 17 North Medical Park Drive, Fishersville, Virginia 22939, email info@eyeoneva.com or call 540-213-7720.

YOU WILL NOT BE RETAILIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS INFORMATION ON THIS ____ DAY OF ___________, 20__.

Patient Name ____

Patient Signature____ Guardian Signature ____________________________________