Wayne R. DeVantier, M.D.

Tom Edmonds, M.D.

Roger W. Newsom, M.D.

Leonard A. Rappaport, M.D.

Mark A. Pavilack, M.D.

Mark J. Iacobucci, M.D.

Kori A. Elkins, M.D.

M. Alison Mercer, O.D.

Joy C. Tomko, O.D.

OFFICES:

Chesapeake

805 N. Battlefield Blvd.
Suite 111
Chesapeake, VA 23320
Phone (757) 483-0400
Fax (757) 548-9563

Portsmouth

3235 Academy Avenue
Suite 200
Portsmouth, VA 23703
Phone (757) 483-0400
Fax (757) 686-0947

Virginia Beach

1564 Laskin Road
Suite 192
Virginia Beach, VA 23451
Phone (757) 483-0400
Fax (757) 422-6246

Dear Patient:

Welcome to our practice and thank you for choosing Tidewater Eye Centers as your eye care team. Rest assured that we will make every effort to provide you with the highest quality care.

Please bring the following with you to your appointment:

- **Completed New Patient forms**
- **A list of all prescribed medications**
- **Insurance cards**
- **Valid Photo ID**
- **Referral (if needed)**
- **Payment method: Check, cash, or credit card**

Your first visit with us could last two hours or more. We may dilate your eyes at this exam which might increase your sensitivity to light or make your vision blurry. If you are sensitive to dilation it may be best to have a driver. We do take a picture of all of our patients to identify them with their electronic medical record.

We have enclosed the new patient forms and a card with the location, time, and date of your appointment. If for any reason you are unable to keep your appointment, please call our office 24 hours in advance to reschedule.

Again, we welcome you to our practice and look forward to seeing you.

Sincerely,

The Doctors and Staff of
Tidewater Eye Centers, P.C.

Wayne R. DeVantier, MD
Roger W. Newsom, MD
Mark A. Pavilack, MD
Kori Elkins, MD

Tom Edmonds, MD
Leonard A. Rappaport, MD
Mark J. Iacobucci, MD
M. Alison Mercer, OD
Joy C. Tomko, OD

(757) 483-0400

Patient Information

PLEASE PRINT

Patient ______________________________

Patient SS# ______________________________
(For insurance purposes only)

Age _____ DOB _____/_____/______

Address ______________________________

____
City State Zip

Sex: ☐ M ☐ F

☐ Single ☐ Married ☐ Separated ☐ Divorced
Spouse's Name ______________________________
Ethnicity________________ Race ______________
Language ________________
Name you prefer to be called______________________

Home( ) ______-______ Work ( ) _____-_______
Cell ( ) ______-______
Email ______________________________
Best time and place to reach you?

____

Family Physician:______________________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

IN CASE OF EMERGENCY, CONTACT
Name______________________________
Relationship______________________________
Hm# __________________ Wk#__________________

How did you hear about Tidewater Eye Centers?
☐Family Member
☐Referral from another patient
Name______________________________
☐Referral from another Doctor
Name______________________________
☐Insurance Co. ☐Internet ☐Radio
☐TV ☐Newspaper ☐Yellow Pages
☐Nursing home/Hospital
☐Tidewater Eye Center Employee

INSURANCE

PRIMARY

Insurance Co. ______________________________

Subscriber Name ______________________________

ID # ______________________________

Group # ______________________________

Relationship to Patient ______________________________

DOB ____/____/_____ SS# _________-_______-_________

SECONDARY

Insurance Co. ______________________________

Subscriber Name ______________________________

ID # ______________________________

Relationship to Patient ______________________________

DOB ____/____/_____ SS# _________-_______-_________

Is patient covered by additional insurance? ☐Yes ☐ No

Insurance Co. ______________________________

Group # ______________________________

Responsible Party:

Name:______________________________

Relationship:______________________________

Address: ______________________Home #___________

Employer:___________________ Work#__ ___________

Responsible Party Signature:

____

PLEASE BE SURE TO SHOW YOUR INSURANCE CARDS TO THE RECEPTIONIST. NOTIFY US OF ANY CHANGES IN YOUR HOME ADDRESS, PHONE NUMBER, OR INSURANCE COVERAGE.

Assignment of Benefits and Financial Policy Agreement

1. As long as you provide us with your insurance documentation on the date of your visit, Tidewater Eye Centers PC will file the insurance claim with the primary, secondary and tertiary insurance carriers as a courtesy to you. However, an insurance policy is a contract between the patient and their insurance company. **You acknowledge that you will be responsible for all charges not paid by the insurance company, except as otherwise specified by law.**

2. It is the patient's responsibility to provide referrals from primary care physicians and other necessary documents, if applicable, no later than the day on which we provide care.

3. All payments are due at the time of service for medical services or date of order for optical services. Such payments include but are not limited to co-pays, deductibles, charges related to insurance plans with which we do not participate and charges for self-pay balances.

4. Accounts with outstanding balances will be turned over to a collection agency if not paid in full by **90 days** following the date of service (for self-pay patients) or the last insurance payment. However, exceptions (that reduce or extend this 90 day period) may be made when reasonable in our judgment on a case-by-case basis or when dictated by requirements set forth by the insurance carrier. Before turning any account over to collections, we will attempt to contact the patient or their responsible party. **PLEASE NOTE: If the account balance is forwarded to a collection agency, the patient will be released from the care of Tidewater Eye Centers.**

5. Monies due on unclaimed optical orders will be turned over to collections as early as 30 days after orders are placed. If optical orders are modified after orders are placed with optical labs, patients may owe a balance on the original order if our optical lab has already cut lenses, etc.

6. If your account is referred to an attorney or collections agency, you agree to pay all collections costs including attorney or collection agency fees of thirty-three and one-third percent **(33 1/3%)** of the principal amount turned to collections.

7. You hereby assign to Tidewater Eye Centers PC for its services to you any benefits available for such services under insurance policies, workers compensation, governmental agency, disability, or other programs. Similarly, you hereby assign to Tidewater Eye Centers PC any proceeds from settlements, judgments or verdicts in your favor from third party liability claims for your injuries treated by Tidewater Eye Centers PC. With respect to such third party liability proceeds, Tidewater Eye Centers PC will be deemed to have a claim in an amount equal to its normal charges for services rendered, together with attorney fees, costs, and interest, as applicable. Tidewater Eye Centers PC will be deemed to have a lien against the proceeds in such amount. You agree that Tidewater Eye Centers, PC will be authorized to receive direct payment of all assigned benefits/ proceeds, and that any attorney, insurance carrier or agency handling or disbursing such benefits or proceeds is hereby authorized and directed to withhold and promptly pay over to Tidewater Eye Centers, PC the lesser of the full amount of its charge or the total proceeds or benefits available, without offset.

8. To the extent necessary to determine liability for payment and to obtain reimbursement, you agree that Tidewater Eye Centers, PC may disclose your record to any appropriate party related to the Social Security Administration, insurance or benefit payer.

9. Tidewater Eye Centers requests that patients give **24 hours notice** when they will not be able to keep a scheduled appointment. **If appropriate notice is not given, Tidewater Eye Centers may charge a $35.00 No Show Fee**. Certain circumstances may allow this fee to be waived by the appropriate director or administrator.

By signing below, you represent that you have read and fully understand this agreement, and that Tidewater Eye Centers, PC has made no representations not stated on this financial policy. Photocopies of this agreement will be deemed to be duplicative originals for all purposes.

Signature: X ____ **Date:** ________________________________

Explanation of Refraction Charge

A refraction is a test that measures your best corrected vision. It is necessary if you would like to have a new glasses prescription, contact lenses, or if you have had a change in your vision. Your doctor can determine if you have nearsightedness, farsightedness, astigmatism, or presbyopia by performing this test.

Even though this is a vital test to the care of your eyes, the refraction test is a non-covered service through Medicare and most medical insurance plans. Medicare and other forms of insurance do not consider a refraction test to be part of a comprehensive eye exam. However, Medicare allows us to charge and be paid for this service. The charge for a refraction test is **$44.00**.

If a refraction test is a necessary part of your exam, we will perform it and you will be asked to pay the fee at check-out. We will also file your insurance and should they cover the test you will be refunded once insurance has provided payment.

Your signature today signifies your understanding of this test.

____

Patient Signature

____

Date

8/30/16rs

Tidewater Eye Centers, P.C.

Medical History Questionnaire

NAME____ DATE__________________

Date of Birth_________ Age____ Family Dr. _________________ Doctors Phone# ______________

What pharmacy do you use?______________________________ Pharmacy Phone# ______________

YOUR PAST MEDICAL HISTORY

Please list all medications you are currently taking, including over the counter and any eye medications. Please include name and dosage. ____

____

Are you ALLERGIC to any medication(s)? **YES NO Please circle one**

If YES, please list and explain reaction: ____

PLEASE CIRCLE IF YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS:

Diabetes / High Blood Pressure / Heart Disease / Thyroid Disease / AIDS / HIV+ / Stroke / Lupus / Arthritis / Rheumatoid Arthritis / Hepatitis / Syphilis / Head Trauma or Injuries / Asthma / Emphysema / High Cholesterol / Cancer, if so, what type:____

Please list any other illnesses not mentioned above:

____

List any surgical procedures (other than eye surgery) you have had:

____

Do you have a Pacemaker or Automated Internal Cardiac Defibrillator (AICD)? **YES NO Please circle one**

REVIEW OF SYSTEMS (ORGAN SYSTEM)

Do you currently have any problems in the following areas? PLEASE CHECK YES OR NO TO EVERY QUESTION. IF YES, PLEASE PROVIDE EXPLANATION.

	YES	**NO**	**EXPLAIN**
General/Constitutional (Fever, Weight Loss, Etc.)	_____	_____	______________________
Ears, Nose, Throat (Sinus, Dry Mouth, Etc.)	_____	_____	______________________
Cardiovascular (Chest Pain, Shortness of Breath, Etc.)	_____	_____	______________________
Respiratory (Wheezing, Coughing, Etc.)	_____	_____	______________________
Gastrointestinal (Upset Stomach, Diarrhea, Etc.)	_____	_____	______________________
Muscles, Bones, Joints (Aches & Pains, Arthritis, Etc.)	_____	_____	______________________
Skin (Rashes, Irritations, Etc.)	_____	_____	______________________
Psychiatric (Depression, Anxiety)	_____	_____	______________________
Neurologic (Weakness, Headaches, Etc.)	_____	_____	______________________
Allergic/Immunologic (Hives, Itching, Etc.)	_____	_____	______________________
Endocrine (Diabetes, Hypothyroid, Etc.)	_____	_____	______________________
Blood/Lymph (Cholesterolemia, Anemia, Etc.)	_____	_____	______________________

(OVER)

PLEASE CHECK YES OR NO FOR EVERY QUESTION BELOW:

Have you ever been diagnosed with any of the following eye problems?

	YES	NO		YES	NO
Cataracts	_____	_____	Tumor of the Eye	_____	_____
Blurred Vision	_____	_____	Herpes of the Eye	_____	_____
Glaucoma	_____	_____	Retinal Problems	_____	_____
Macular Degeneration	_____	_____	Eye Injury	_____	_____
Crossed Eye	_____	_____	Eye Infections	_____	_____
Lazy Eye	_____	_____	Iritis	_____	_____

Other____

Please check any vision problems you may be experiencing **WITH YOUR GLASSES ON**:

___ Reading Newspaper

___ Reading Medicine Bottles/Phone Book

___ Seeing to Sew

___ Watching Television

___ Difficulty with Sports, Hobbies, Etc.

___ Seeing Road Signs

___ Driving at Night Due to Glare

___ Seeing Halos Around Lights

___ Glare from Sunlight

___ Difficulty with Home/Work Related Activities

List any other specific vision problems you may be experiencing: ________________________________

YOUR EYE HISTORY

Date of last eye exam: ___________________ Do you currently wear contact lenses? **YES** **NO**

If Yes, what kind do you wear? ________________________________ How many years? ________________________

Do you wear prescription eyeglasses? **YES** **NO** If yes, how old are your current glasses? ________________

List any eye surgeries or laser treatments you have had, including the date and surgeon's name:

____

____

FAMILY HISTORY

Do you have a family history of Diabetes, Coronary artery disease, Cancer, Lupus, Rheumatoid arthritis, Thyroid disease, Glaucoma, Macular degeneration or other inherited eye disease? **YES** **NO**

If yes please list disease and family members affected: ________________________________

SOCIAL HISTORY

Current Occupation: ____

Do you drink alcohol? **YES** **NO** If Yes: occasional 1 day 2-3 day 4+ day

Do you smoke? **YES** **NO** If Yes: occasional: 1/2 pack day 1 pack day 1+ pack day

Physician's Signature: ____