

# Welcome to Ryan Vision Center

## HIPPA COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

Your information is kept confidential and we comply with the Health Insurance Portability Act. Inactive records are professionally destroyed after 5 years.

Patient's Name: \_\_\_\_\_

Address \_\_\_\_\_

City Richmond  \_\_\_\_\_ State VA  \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Married  Single  Other  Child  Male  Female

Birthdate \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Employer Name \_\_\_\_\_

Eye-Care Insur Co: VSP  Davis/Cap.1  EyeMed/BluVu  None  Other \_\_\_\_\_

**Medical Insur Co:** leave card attached to this clipboard for us to copy

\_\_\_\_\_ Group \_\_\_\_\_ I.D. \_\_\_\_\_

Patient's relationship to insured: Self  Spouse  Child  Partner  Other

**Please note there will be a charge of \$28 for the retinal photos, this is not covered by insurance as they consider it "elective".**

We will bill most insurance carriers for you when proper paperwork is provided to us. Since your agreement with your insurance carrier is a private one, we do not research why an insurance carrier has not paid or why it paid less than anticipated for care. If insurance carrier has not paid within 90 day of billing, fees are due and payable in full from you. I authorize payment directly to our office for services rendered. As the responsible party, I authorize the release of any medical records needed to obtain payment from my insurance company. I understand that if the account is delinquent it will be turned over to a collection agency. I will be responsible for all costs of collection, including and not limited to collection fees and attorney fees, and court costs.

Signature: \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(If under 18, Parent or Guardian's Signature)

Reason for your visit? (chief complaint) \_\_\_\_\_

Allergies to any medications? No  Yes : Penicillin  Codeine  Sulfa Drugs  Other \_\_\_\_\_

List any medications you are currently taking \_\_\_\_\_

Are you interested or may be interested in Lasik someday. Yes  No  We can provide your pre and post op care.

Do you have a history of problems adjusting to a new prescription or contacts? Yes  No

Interested in being evaluated for contacts today? Yes  No  Do you want to purchase them here today? yes  no

Want to stay with same brand? yes  or would like to go with today's best recommended lenses

Planning on purchasing glasses today Yes  no

**Please Note: There will be a Contact Lens Evaluation Fee charged in addition to the Routine Eye Exam Fee. This charge may not be covered by your insurance.**

Medical History	Self		Family	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other breathing difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you smoke	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Any other eye conditions or history of them? \_\_\_\_\_

Any other medical conditions that we should be aware of? \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_