



ASHLEY SCHAUER, M.D. - ANDREW COLLINS, M.D. - ELLEN CHANCE SANDERS, M.D.

Dear New Patient,

Thank you for scheduling a visit with us.

Please come 15 minutes before your appointment to allow for parking and finding the office.

- Please take a few moments to fill out the following paper work, and **bring it with you to your appointment.**
- If you need to cancel your appointment or reschedule please give us a 24-hour notice.
- Please bring your insurance card, driver's license/picture ID and glasses in with you. **If you have a vision care plan, we do not participate with these plans and will only bill your insurance if something is medically wrong with your eyes.**
- If you wear contact lenses please bring an unopened sample or a written prescription for them from your previous eye doctor
- If this is a pre-deployment exam, we will not bill your vision care plan and you will be responsible for your bill and can seek reimbursement from your employer
- Bring a complete up-to-date medication list or all of your medications including eye drops with you

Notice to Our Patients Regarding the Refraction Charge

- Refraction is the procedure in which we determine the best corrected visual acuity of each eye for purposes of medical evaluation or for prescribing spectacles or contact lenses. For most insurances, including **Medicare**, there is no provision for coverage of this procedure and there is no indication that it will likely become a covered service anytime in the future.
- Refraction is necessary to adequately determine visual function and is important in making sure that serious underlying eye problems do not exist. We perform refractions as a part of all of our comprehensive eye evaluations.
- We trust that you will understand the need to perform this procedure and we respectfully ask for payment at the time of service

Thank you for selecting us for your eye care. We look forward to seeing you.

Drs. Schauer, Collins, Sanders and Staff



ASHLEY SCHAUER, M.D. - ANDREW COLLINS, M.D. - ELLEN CHANCE SANDERS, M.D.

NAME: _____ Date of Birth: _____
(First) (Middle Initial) (Last)

Gender (circle): Male / Female Social Security number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: (Home) _____ (Work) _____ (Mobile) _____

Marital Status: _____ Contact preference (circle): Home phone / Cell phone / Text message / Email

Email Address: _____ Employer: _____

Who referred you? _____ Primary Care Doctor: _____

The following is requested for the Meaningful Use Project directed by the Dept. of Health and Human Services (HHS)

Race (circle): Hispanic / White / Asian / Black/African American / American Indian
Hawaiian/Pacific Islander / Other

Ethnicity (circle): Hispanic / Non-Hispanic / Unknown

Primary Language (circle): English / Spanish / Other: _____

Smoking History (circle): Every Day Smoker / Some Days / Former / Never Smoked

Financial Responsibility (If you are a minor or someone else is responsible for payment)

Name: _____ Relationship to Patient: _____

Social Security Number: _____ - _____ - _____

Address: _____

Phone number: (Home) _____ (Work) _____ (Mobile) _____

I hereby authorize payment directly to Blue Ridge Ophthalmology (Drs. Schauer/Collins/Sanders) all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf. I authorize the above noted doctor and/or any provider or supplier of service in this office to release information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that obtaining a referral from my primary care doctor does not guarantee insurance coverage for this visit.

For Medicare patients (and some other insurance carriers): I request that payment under the Medicare Insurance Program be made to me or on my behalf to the above noted doctor for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. Furthermore, I am aware that the Medicare program may not pay for all services rendered. For example, routine eye examinations and determining glasses' prescriptions ("refractions") are not Medicare benefits.

I understand that any unpaid balance that is not covered by insurance may be turned over to a collection agency with failure to pay within (3) billing cycles, and I agree to pay the cost of collection, court costs and reasonable attorney fees. I also agree to pay interest on any outstanding balance with failure to pay on (3) billing cycles at the rate of 18% annually.

Signature: _____ Date: _____



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Patient: _____

Reason for today's visit:

Medical History / Systems Review (list or write none) (may continue on back)

General: _____
Ears/Nose/Throat: _____
Heart/Blood Vessels: _____
Lungs/Breathing: _____
Stomach/Intestines: _____
Kidneys/Bladder/Prostate: _____
Joints/Muscles: _____
Skin: _____
Brain/Nerves: _____
Mental Health: _____
Endocrine/Diabetes: _____
Blood: _____
Allergy/Immune: _____

Social History:

Occupation: _____ Smoking: _____

Your Eye History (check all that apply):

None Glasses Contact Lenses: soft / hard Lazy Eye Cataract Macular Degeneration Glaucoma
 Diabetic Retinopathy Eye Injury(s): _____
 Eye Surgery(s): _____

Family Eye History (check all that apply):

Glaucoma Macular Degeneration Cataract Lazy Eye Cancer of Eye
 Other: _____

Allergies to Medicines (list):

Medications (please list):

Are you taking Coumadin (blood thinner)? Yes / No
Are you taking Flomax or other urination medicine? Yes / No

Surgeries (list):



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CONTACT LENS POLICY *(please read and sign only if you want contacts)*

New contact lens patients

For patients new to contact lenses the examination fee is \$240. This includes a complete ophthalmic examination (\$150 value), glasses' prescription, contact lens fitting, instruction on the care of contact lenses, an introductory lens-care kit, complimentary trial lenses (soft lens wearers only), and all contact lens related follow-up visits for 60 days. **This does *not* include the cost of the lenses themselves.** However, no lenses will be ordered before the patient is told their cost in advance.

Patients currently wearing contact lenses

The fee for patients currently wearing contact lenses who feel their lenses need to be replaced or changed is \$195. This includes a complete ophthalmic examination (\$150 value), glasses' prescription, evaluation of their current contact lenses and adjustment of the fit and power as indicated, and all contact lens related follow-up visits for 45 days. As stated above, **the contact lenses themselves are an additional fee.**

Warranty

Your non-disposable soft contact lenses or rigid gas permeable lenses may come with a warranty (typically 90 days) during which they may be exchanged for another lens. If they fall outside of the warranty period because of a delay in a patient picking them up or scheduling an appointment to try them on, the patient will be responsible for the cost of the new lens(es).

Additional notes

Examination fees are due on the date of service. We do not bill insurance companies for contact lens examinations, but we will be glad to provide you with an itemized bill if you feel you can be reimbursed by your medical plan. For new contact lens wearers, rigid lens wearers and patients wearing toric lenses the initial order of contact lenses must be made through our office to ensure that they are properly fitted.

Disposable soft lens wearers who know the brand, power and fitting parameters of their current lenses can purchase their contact lenses through our office or receive a prescription to purchase their lenses elsewhere once they have been examined and found to be properly fitted.

I have read and understand this information:

Signature: _____ **Date:** _____



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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations *(Please Read and Sign)*

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- 1) A basis for planning my care and treatment.
- 2) A means of communication among the health professionals who contribute to my care.
- 3) A source of information for applying my diagnosis and surgical information to my bill.
- 4) A means by which a third-party payer can verify that services billed were actually provided.
- 5) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional.

In addition I understand the following:

- a. A Privacy Notice from Blue Ridge Ophthalmology, PLLC has been made available that provides a more complete description of information uses and disclosures.
- b. I have the right to review the notice prior to signing this consent.
- c. Blue Ridge Ophthalmology reserves the right to change its notices and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided.
- d. I have the right to object to the use of my health information for directory purposes.
- e. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- f. I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept the terms of this consent.

Signature: _____ **Date:** _____



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Request for Confidential Communication

I, _____, hereby request **Blue Ridge Ophthalmology** to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at _____ or _____
Leave messages on the answering machine (circle): Yes / No
Leave messages with any other person (circle): Yes / No

With Whom (name): _____

Mail: Contact me at the following address: _____

Fax: _____ **NO**, please **do not** contact me by FAX
_____ **YES**, please contact me by FAX at _____

Other Requests for Confidential Communications:

Signature: _____ **Date:** _____

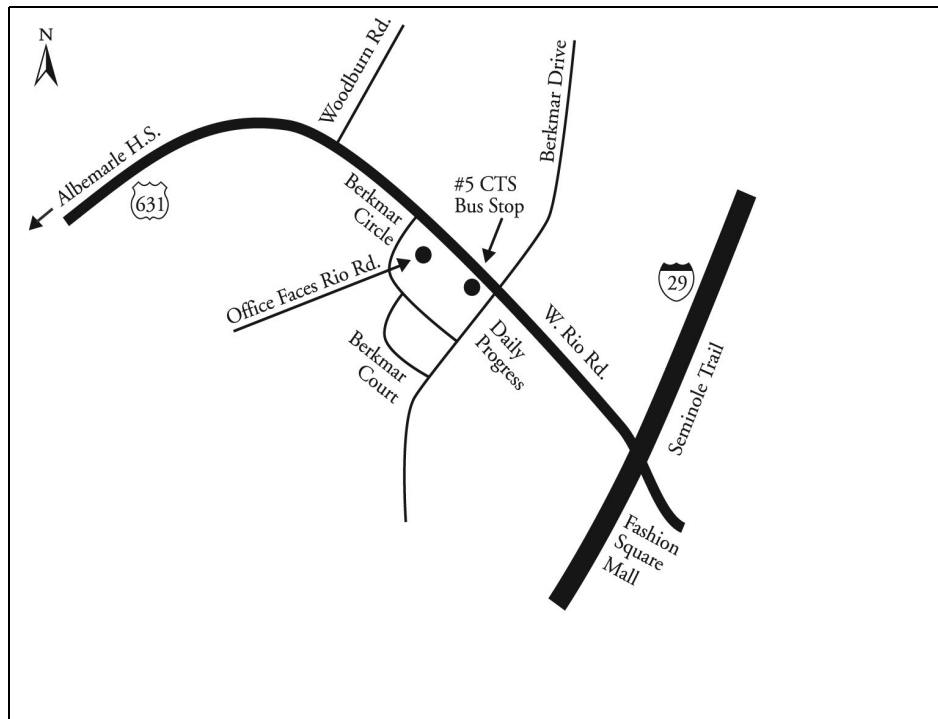
If you are not the patient, please specify your relationship to the patient: _____

Directions

We are at 626 Berkmar Circle, within the Berkmar Crossing Shopping Center. ***Our building faces Rio Road.***

From Route 29 South, heading north toward Wal-Mart, turn left onto Rio Road. Coming from the North, heading south toward Fashion Square Mall, turn right onto Rio Road. Pass through the next stop light at Berkmar Drive. Turn left into the shopping center just past the light. Our building is the only one story building on the left facing Rio Road.

If you are unfamiliar with the area and you need further assistance, please call us before the day of you appointment and we will be glad to give you more detailed instructions.





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Aesthetic Self-Assessment

Please complete the following questionnaire *if you are interested* in knowing more about our medical grade skincare products we offer or the cosmetic procedures that Dr. Sanders performs. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

1. What aesthetic treatments and procedures, if any, have you had in the past?

2. If you have previously had any aesthetic treatments or procedures, and you were not pleased with the outcome, please explain why you were dissatisfied.

3. Do you have any concerns about aesthetic treatments or procedures? If yes, please explain.

4. Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply.

- Topical wrinkle treatments
- Botulinum toxin A (Botox)
- Dermal fillers (Restylane, Perlane, Juvederm)
- Professional skin care products
- Skin rejuvenation
- AHA and glycolic peels
- Sunscreen advice
- Other _____