STAUNTON EYE CLINIC, P.L.C.

2010 N. AUGUSTA STREET
STAUNTON, VA 24401
(540) 885-8186 FAX (540)886-5895

John A. Stathos, Jr., M.D.
Doctor of Ophthalmology
Diplomates, American Board of Ophthalmology
Fellows, American Academy of Ophthalmology

Patient Name _____

Your Appointment is on _____ (day of the Week)

the _____ (date) _____(month) @ _____ (time).

- WELCOME: Thank You For Choosing Staunton Eye Clinic For Your Complete Eye Care! We Look Forward to Serving You!

- Your exam will be at least 1 1/2 hours. Please allow time in your schedule accordingly.

- Please Remember to bring to your appointment:
    1. Enclosed New Patient Forms
    2. Current Insurance Cards
    3. Current Medications and dosages
    4. Your Copay
    5. Most Current glasses and Contact Lens
    6. Last vision exam (if possible) Our Fax # is above if requesting from last office

- For your convenience , if your appointment is for a medical exam we will file your claim for you with your medical insurance. We are providers with most vision plans. You may want to inquire about your vision plan coverage prior to your appointment. Vision plans we participate in include: Eye Med, Vision Services Plan (VSP), Davis, Versant Health, Superior, Spectera to name a few.

- Dilated pupils may impair vision. However, most patients function well after dilation with sunglasses. Each patient will need to use their own discretion if a driver is needed.

- ***IF YOU CANNOT KEEP YOU APPOINTMENT - ** KINDLY GIVE A 24 HOUR NOTICE

- IF YOU HAVE ANY QUESTIONS, PRIOR TO YOU APPOINTMENT, PLEASE GIVE US A CALL

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PATIENT INFORMATION SHEET

CHART# _____ DATE_____

NAME_____ MALE____ FEMALE____
LAST FIRST MIDDLE MAIDEN

ADDRESS_____
STREET - APT CITY STATE ZIP

DATE OF BIRTH_____ SOCIAL SECURITY#_____

HOME PHONE#_____ CELL PHONE#_____

MARRIED_____ WIDOWED_____ SINGLE_____ DIVORCED_____ SEPARATED_____

EMPLOYER_____ PHONE#_____

OCCUPATION_____

MAY WE CONTACT YOU AT WORK?_____

SPOUSE_____ PHONE#_____

EMPLOYER_____

OCCUPATION_____

(IF PATIENT IS A MINOR PLEASE COMPLETE BELOW)

PARENTS: MOTHER_____ FATHER_____

EMPLOYER_____ EMPLOYER _____

PHONE# _____ PHONE# _____

OCCUPATION_____ OCCUPATION_____

EMERGENCY CONTACT_____ PHONE#_____

RELATIONSHIP_____

MEDICAL DOCTOR_____ PHONE#_____

PHARMACY_____ PHONE#_____

PRIMARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY #_____

INSURANCE COMPANY_____ POLICY #_____

SECONDARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY #_____

INSURANCE COMPANY_____ POLICY #_____

I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF ANY CHARGES NOT COVERED BY MY INSURANCE

DATE_____ SIGNATURE_____

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By signing this form, I authorize the use and disclosure of my health information as described below:

1. **The purpose of this agreement is to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under HIPPA requires us to maintain the privacy of medical information provided to us.**

2. **What information can be disclosed? Your name, address, phone number, and information relating to the medical history. Insurance information, appointments, mailings and coverage information concerning your medical providers.**

3. **Who can disclose this information? Employees and staff of the Staunton Eye Clinic, P.L.C. Are authorized to make use or disclose required health information.**

4. **To whom can this information be disclosed? Organized health care entities or other medical providers in relationship to the patient's health care can receive this information.**

5. **Please list below any family members, guardians, employers, etc. To whom your medical information can be disclosed.**

1._____ **2.**_____
3._____ **4.**_____

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 based upon my original permission, or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Staunton Eye Clinic, P.L.C.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the federal Privacy Standards. I understand that Staunton Eye Clinic, P.L.C. May not condition treatment on my signing this authorization and that I have the right to refuse to sign this authorization.

Print Patients name:_____
Patient Signature:_____ **Date:**_____

STAUNTON EYE CLINIC, P.L.C.
MEDICAL INFORMATION

NAME_____ **CHART#**_____
LAST **FIRST** **MIDDLE** **MAIDEN**

MEDICATION ALLERGIES:_____

_____

_____

PAST MEDICAL HISTORY:_____

_____

_____

PAST SURGICAL HISTORY:_____

_____

_____

CURRENT MEDICATIONS: NAME, DOSAGE, & REASON

1._____ _____ 16._____ _____
2._____ _____ 17._____ _____
3._____ _____ 18._____ _____
4._____ _____ 19._____ _____
5._____ _____ 20._____ _____
6._____ _____ 21._____ _____
7._____ _____ 22._____ _____
8._____ _____ 23._____ _____
9._____ _____ 24._____ _____
10._____ _____ 25._____ _____
11._____ _____ 26._____ _____
12._____ _____ 27._____ _____
13._____ _____ 28._____ _____
14._____ _____ 29._____ _____
15._____ _____ 30._____ _____

FAMILY HISTORY: (LIST WHICH IMMEDIATE FAMILY MEMBER(S))

CATARACTS_____ DIABETES_____
GLAUCOMA_____ HIGH BLOOD PRESSURE_____
RETINAL DETACHMENT_____ HEART DISEASE_____
EYE DISORDER_____ OTHER_____

SOCIAL HISTORY:

DRUGS_____ ALCOHOL_____ TOBACCO_____ DEPENDENCY STATUS_____

STAUNTON EYE CLINIC, P.L.C.

OFFICE USE ONLY

NAME: _____ CHART# _____

LAST FIRST MIDDLE MAIDEN

OCULAR HISTORY

DIAGNOSIS

1._____ 10._____
2._____ 11._____
3._____ 12._____
4._____ 13._____
5._____ 14._____
6._____ 15._____
7._____ 16._____
8._____ 17._____
9._____ 18._____

OCULAR MEDICATIONS

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

PROCEDURES

1._____ 10._____
2._____ 11._____
3._____ 12._____
4._____ 13._____
5._____ 14._____
6._____ 15._____
7._____ 16._____
8._____ 17._____
9._____ 18._____

PFSH + ROS UPDATED: (YEAR & INITIALS)

_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____

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PAYMENT POLICY
PAYMENT IS DUE AT THE TIME OF SERVICE

We are committed to providing you with the best possible care. Co-Pays and deductibles that have not been met are due at the time of your visit. If we are not a provider with your insurance company, payment is expected at the time of your visit. If you have a medical/vision insurance, we will file your claims or provide you with a receipt for you to submit.

If your glasses prescription is updated (refraction) there will be a $25.00 fee due at the time of your visit. **MOST INSURANCES WILL NOT COVER REFRACTIONS** unless you have a vision plan on your policy, in which case you will be responsible for any co-pays your insurance plan requires you to pay at the time of service. Also, it is the patient's responsibility to provide a referral if one is needed.

Your account will be considered past due if not paid within 90 days of our initial bill. In addition to the principle amount owed, should your account become past due, you agree to pay us a liquidated damages calculated at 25% of the current principal balance on your account in addition to attorney's fees, court cost and interest at 1 ½% from the date of service.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BILL AND WILL PAY ANY BALANCE DUE THE STAUNTON EYE CLINIC P.L.C.

PATIENT NAME (PLEASE PRINT)_____

PATIENT SIGNATURE (SEAL)_____
DATE____/____/_____

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Informed Consent: COVID-19

I understand that I am consenting to an elective specialist visit, procedure or surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to be spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective specialist visit and can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during and after my specialist office visit may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term and long-term intubation, other complications, and death. After my elective visit I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective visit may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the specialist office visit, procedure or surgery listed below.

I have have been given the choice to have my specialist visit, procedure or surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient:_____ **Patient date of birth:**___/___/____
(print)

Name of provider: John A. Stathos Jr. M.D. **Signature of provider:**_____

Specialist office visit includes today's date and all future dates of service at Staunton Eye Clinic

Patient Signature:_____ **Date:**____/____/____