NoVA Eye MD

Nisha R. Patel, MD

Board Certified Eye Physician, Surgeon and Cornea Specialist

PATIENT INFORMATION

Name:	DOB:	Age:	___ Female ___ Male
Ethnicity:	Preferred Language:		
Address:			
City:	State:	Zip:	
CELL PHONE:	Home:	Work:	
Email Address:			
Ok to send email/text/voice reminders of your appointments? ___ YES ___ NO			
SSN:	Employer:	Occupation:	
Marital Status:	Spouse's Name:		
Primary Care Physician:		Phone:	
Primary Insurance:		Policy Holder:	
Policy Holder DOB:	ID#:	GRP#:	
How did you hear about us?			

*5900 Fort Drive, Suite 425, Centreville, VA, 20121 * 703-263 3147 * fax 703-263-3148*
*407 Church Street NE, Suite E, Vienna, VA, 22180 * 703-242-8200 * fax 703-242-8203*
*www.novaeyemd.com * novaeyemd@yahoo.com * novaeyemdinc@gmail.com*

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OFFICE FINANCIAL POLICY

_____ (initial) BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards. There is a **$25.00** returned check fee due and payable from you for each check payment returned to us by your bank. The office will charge a **$25.00** fee in the event that a patient does not provide notice of cancellation at least 24 hours prior to their scheduled appointment.

_____ (initial) PATIENTS WITH INSURANCE: We will bill your insurance carrier(s), provided proper documentation is provided to us. Every effort will be made to estimate your copayments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. Please note that we are not responsible for obtaining referrals required by your insurance plan. It is the sole responsibility of the patient to obtain a referral from your Primary Care before the date of service.

_____ (initial) SURGERY FEES/NON-COVERED CHARGES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your insurance carrier. Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

_____ (initial) PATIENT RESPONSIBILITY: The office has the right to obtain a copy of a valid credit card for all deductibles and services not covered by insurance. Once an explanation of benefit has been obtained by Dr. Patel's office and the patient has been notified of his/her responsibility, the card will be charged for the outstanding balance. In the event that the patient account has delinquent status, Dr. Patel's office reserves the right to send the account to a collection agency and the patient agrees to pay the cost of collections. Guarantors acknowledge accounts referred to a collection agency or attorney may be subject to a collection fee of 35% of the balance in addition to the total balance due and all legal fees associated with outstanding patient financial responsibilities.

_____ (initial) MEDICAL RECORDS RELEASE: There is a **$10.00 fee** for release of medical records, **+$.50 per page**, charged to each patient upon requesting medical records.

I have read, understood and agree to the above financial policy. I understand that I am ultimately responsible for all fees and referrals for services provided to me. Anything that is returned as unpaid by insurance is my sole responsibility.

Patient Name (PRINT) _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (Print): _____Relationship to Patient: _____

Signature: _____ Date: _____

AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION:

Home phone: _____ Ok to leave a detailed message? ___ Yes ___ No

Cell Phone: _____ Ok to leave a detailed message? ___ Yes ___ No

Work Phone: _____ Ok to leave a detailed message? ___ Yes ___ No

I authorize Nova Eye M.D., Inc. to discuss/share protected health information about me with the following individual(s) who are involved in my care:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone:_____

Patient Signature: _____ Date: _____

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COVID-19 Pandemic Emergency Ophthalmic Treatment Consent Form

I, _____(PRINT), knowingly and willingly consent to have emergency ophthalmic treatment completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with ophthalmology. _____ (Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)

- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)

Signature: _____ Date_____

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REFRACTION FEE POLICY:

Please review the following options, and initial the option applicable for your visit today:

❏ Yes, I would like to receive an exam for an eyeglass prescription. I am aware that this service will not be billed to my insurance and I will be responsible for a **$55.00** refraction fee.

❏ Yes, I would like to receive an exam for a contact lens prescription. I am aware that this service will not be billed to my insurance and I will be responsible for a **$175.00** contact lens fit fee if I am a previous contact lens wearer, and **$300.00** if I am not a previous contact lens wearer and require insertion and removal instructions sessions. Hard Contact lens fit fee is **$300.00** for fit and **$300.00** for lenses and scleral contact fees are determined by difficulty of fitting.

❏ No, I do not want an eye exam for a current eyeglass or contact lens prescription.

❏ Unsure, I would like Dr. Patel to complete her assessment and determine whether I need an eyeglass prescription. I am aware that this service will not be billed to insurance and I will be responsible for a **$55.00** refraction fee.

Patient Name (Printed): _____

Signature: _____ Date: _____

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Are you interested in a Complimentary Consultation on Cosmetic Services?

Please check the services you are interested in:

- ❑ **Botox:** Reduction of fine lines
- ❑ **Juvederm:** Collagen filler to reduce appearance of fine lines
- ❑ **Voluma:** Collagen filler for facial rejuvenation
- ❑ **Kybella:** Helps reduce the appearance of excess fat from under the chin
- ❑ **Blepharoplasty:** Upper eyelid rejuvenation
- ❑ **Premium Intraocular Lens Implants**
- ❑ **Laser Vision Correction**
- ❑ **Implantable Contact Lenses:** For patients who are not a candidate for LASIK/PRK

Please check the products you are interested in:

- ❑ **TNS Essential Serum**
- ❑ **TNS Eye Repair:** Reduces fine lines, dark circles and puffiness
- ❑ **Revitabrow:** Thickens eyebrow
- ❑ **Revitalash Brow Gel**
- ❑ **Eye Vitamins:** For Dry Eye and Macular Degeneration
- ❑ **Cliradex:** Treatment of Blepharitis
- ❑ **Tranquil Eyes:** Goggles for Dry Eye
- ❑ No, I'm not interested in a cosmetic consultation

Patient Name (Printed): _____

Signature: _____ Date: _____

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