

Patient's Name (First, MI, Last)		Sex	Soc. Sec. No.	Date of Birth	Marital Status
Street Address (Include Apt No.), City, State, Zip Code					Primary Phone
Other Names You Have Gone By (Maiden, Former Married)					Secondary Phone
Email Address					Other Phone
Employer Name, Street Address, City, State, Zip Code			Occupation	Work Phone	
Spouse's Name (First, MI, Last)		Soc. Sec. No.	Home Phone	Work Phone	
Name of nearest relative not residing with you		Relationship	Street, City, State, Zip	Home Phone	
Name of person making treatment decisions		Soc. Sec. No.	Relationship to Patient	Birthdate	
Street Address (Include Apt. No.), City, State, Zip Code					Home Phone
Primary Medical Insurance			Policy Holder's Name (As printed on card)		
Policy Holder's Soc. Sec. Number		Policy Number(As printed on card)		Relationship to Patient	Date of Birth
Routine Vision Plan and/or Secondary Insurance			How did you hear about our practice?		
Primary Physician		Phone Number:		Optometrist	
				Phone Number:	
Patient's or Guardian Signature		Date		STAFF ONLY	
Patient's or Guardian Signature		Date			
Patient's or Guardian Signature		Date			
Patient's or Guardian Signature		Date			
Patient's or Guardian Signature		Date			
Patient's or Guardian Signature		Date			



Hampton Roads Eye Associates

A Division of Riverside Medical Group



PATIENT AGREEMENT

REFRACTION CHARGES

A REFRACTION is a diagnostic test used to determine the patient's best ability to see. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This test is performed during your annual eye exam or if there has been a decrease in your vision since your last visit. This test is necessary to perform in order for your physician to determine the best visual acuity (vision) which is needed to evaluate for possible eye diseases.

SOME INSURANCE COMPANIES, INCLUDING MEDICARE, DO NOT COVER THE REFRACTION TEST.

The usual charge for this service is \$50.00. If my insurance does not cover this test, a time of service discount of 40% is offered. Therefore, if I pay today, my out of pocket expense is only \$30.00. If I am unable to pay today, my charge will be sent through the billing service and I will be billed for the full fee of \$50.00.

Initials _____ Date _____

RETURN APPOINTMENTS

I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Hampton Roads Eye Associates, its Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice, may be charged to my account.

Initials _____ Date _____

RIVERSIDE MEDICAL GROUP
PATIENT RESPONSIBILITY AND FINANCIAL AGREEMENT

Specify RMG Facility _____

As a patient of this Riverside Medical Group practice, I agree to the following:

- 1. MEDICAL TREATMENT RISKS:** I acknowledge that all medical treatment involves some risks and that no guarantees can be given regarding the outcome.
- 2. RELEASE OF PRESCRIPTION HISTORY:** I authorize any provider who is treating me on behalf of RMG or any Riverside facility to request and receive any and all information regarding my medication history including information maintained by the Virginia Prescription Monitoring Program as well as other state and commercial sources.
- 3. HIV TESTING DISCLOSURE:** Under Virginia law, if an RMG employee comes in contact with your blood or body fluids during your care, RMG has the right to do a current HIV and Hepatitis B or C screening. This means that you, the Patient, may be tested for HIV, Hepatitis B or C viruses without your actual consent if this type of exposure occurs during your medical care. The law also requires that the results of these tests be released to the person who is exposed to your body fluids without your consent.
- 4. FINANCIAL RESPONSIBILITIES:** I assign any benefits to RMG that I may have for reimbursement for my medical treatment received by RMG which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay my outstanding RMG balance, I understand RMG will have a lien against any such settlement, judgment or verdict equal to the full amount of any unpaid RMG bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay to RMG the full amount of any outstanding balance owed by me, the Patient, to RMG for medical services rendered. I also understand and agree to pay a \$30 fee incurred for any returned checks.
- 5. ALL PAYMENTS DUE AT TIME OF SERVICE:** While RMG as a courtesy to patients will bill most insurance companies; RMG is under no obligation to do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility of all RMG charges. Full payment is required at the time of service unless other arrangements are made. If any RMG bill is not paid in full at the time of service, RMG reserves the right to charge interest at a rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and/or attorney fees associated with recovering any outstanding balance. I agree this Agreement is an original, direct, independent promise to pay based on the independent credit worthiness of the Patient or Responsible Party, and is not a collateral or contingent promise to pay the debt of another. Moreover, I authorize RMG to apply any overpayment from another RMG medical bill to any other accounts owed by the Patient to RMG as a result of any prior treatment or admissions.
- 6. PREAUTHORIZATION RESPONSIBILITY:** I understand it is my sole responsibility to obtain all required pre-authorizations for treatment and to fully comply with all pre-authorization requirements as stated by my insurance company. I also understand that if I elect to be treated without a referral from an authorized physician, it is my sole responsibility to pay that treating physician.
- 7. MULTIPLE BILLS:** I understand that while I am receiving medical treatment at a RMG practice, I may receive a separate bill from a health care provider and/or laboratory other than a bill from the office listed above. For example, I may receive a separate bill from a laboratory, radiologist, pathologist, and other providers. I agree to pay any outside bills received to the extent that it is not paid by my insurance.
- 8. DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:** I authorize RMG to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment.
- 9. PATIENT/FAMILY CONDUCT:** While in any RMG office, I agree to be respectful and courteous to the RMG Staff, all medical providers and other patients. I realize the importance of honoring my scheduled appointments and agree to provide adequate notice for rescheduling appointments. Failure to keep appointments or rescheduling without adequate notice may result in consequences including a charge for the missed appointment. Repeated cancellations may result in discharge from the practice.

10. **RMG IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ITEMS:** RMG will not be responsible for any loss, theft or damage to any personal property of the Patient (including money, jewelry, documents, clothing, spectacles, dentures, prosthetic devices or other personal articles).

EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH AND EVERY TERM AND PROVISION OF THIS AGREEMENT.

_____	_____	_____
Print Patient's Name	Date of Birth	Date & Time
_____		_____
Patient or Responsible Party Signature		Relationship to Patient

NOTICE OF PRIVACY PRACTICES:

I am aware of and/or have received Riverside's Notice of Privacy Practices brochure. Upon receiving an inquiry as to the presence or condition of the Patient, RMG may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion: the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my written medical records.

However, I hereby give permission to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

FOR OFFICE USE ONLY:

Patient Unavailable for Signature If Patient unable to sign, Give Reason _____
 Patient does not want to receive a copy of this document. Patient requested and was provided a copy of this document.
 No Responsible Person Available Staff Member Initials: _____ Date: _____



Phytel Appointment Reminder System

Riverside Medical Group is now utilizing the Phytel – Appointment Reminder System. Approximately 48 hours prior to your scheduled appointment, our Phytel computer system will generate a call to your home. The system will give a recorded message to the person answering the phone, detailing your appointment date and time.

The person answering the phone will then be given the option to confirm, cancel, or reschedule the appointment. If you choose to cancel or reschedule your appointment a staff member will call you the following day to confirm this option and schedule a new appointment. If there is no answer at your home number, then the recorded message will be left on your answering machine.

Would you like to receive appointment reminder calls from Riverside Medical Group?

- YES**, I wish for Riverside Medical Group to utilize the Phytel appointment reminder system to remind me of any future appointments. I understand that the Phytel system will automatically deliver the message to anyone answering the phone or leave the message on my answering machine.

- NO**, I do NOT wish for Riverside Medical Group to utilize the Phytel appointment reminder system to remind me of any future appointments.

Patient's Name: _____ Date of Birth: _____

Phone Number: _____

Signature: _____ Date: _____

