Dr. George Worthy Pegram III *801 Poindexter Street, St.115 Chesapeake VA 23324 (757)545-3930*

Authorization: Please read and sign below.

I authorize the doctor to release any information including diagnosis, records of treatment, or examination rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners. _____ (Initials)

Dr. George Worthy Pegram III and associates is committed to caring for our patient's complete ocular health. Our patients will receive a **complete eye examination**. Our doctors are trained to diagnose and treat most ocular diseases. As a courtesy to our patients, we are happy to field with your insurance company. **NOTE**: The patient is responsible for any co-pays and/or deductibles which your insurance requires. I agree to be responsible for payment of all services rendered on my behalf or my dependents. _____(Initials)

Routine Eye Exams will be filed with a patient's vision plan if they have one. A routine eye exam means there is not a medical diagnosis.

If a **Medical Diagnosis** is determined by the doctor, the patient's exam is no longer routine but medical. This means we will bill your Medical insurance. We request a copy of your medical card in your chart for these reasons.
I have read and understand when my **Vision Plan** will be billed and when my **Medical Insurance** will be billed by Dr. George Worthy Pegram III and associates.

The Health Insurance Portability and Accountability act of 1996 (HIPPA) Privacy Notice: I have been presented a copy of the HIPPA Privacy Act. I have read it and understand the content. I know that at any time I can request my own personal copy of the form. _____(Initials)

Financial Assignment and Agreement

- All fees for frames, lenses, additional add-on's, and contact lenses are due before an order can be placed. Any balance on accounts must be paid before future services are rendered. All money paid on account for glasses is NON-REFUNDALE.
- All returned checks will result in a $35.00 service charge.
- In an event that my account becomes a delinquent and is assigned to a collection agency, I agree to pay all costs related to the collection of my debt, including court and attorney fees.
- All exam fees associated with office visits are due at the time of service and are NON-REFUNDABLE.

Contact Lens Services: Many insurance companies regard contact lens as "cosmetic" and not "medically necessary." Therefore many plans will not pay for contact lens services or materials. Contact Lens fees are NON-REFUNDABLE. Contact lens fit and follow-up services are valid 45 days from original date of exam. After the 45 day period, patients will be charged an additional cornea re-check/refraction fee.

- I understand that this practice reserves the right to charge a fee of $50, as of July 1st 2016, should I fail to show up later than 15 minutes for my scheduled appointment and not notify the office of a cancellation within 24 hours of my appointment time.
- We believe that all patients should be treated with dignity. We reserve the right to terminate a patient from the practice in those rare cases when a patient may be verbally or physically abusive, refuse to give necessary information, or is non-compliant with ocular instructions, treatment, and advice.

CUSTODIAL PARENTS OR PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. We will communicate about treatment and payment with the parent/guardian who signs the child in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

Signature of Patient or Responsible Party:_____ **Date**:_____

Medical History Questionnaire

Name:_____ Today's Date: ___/___/_____

Address:_____ City:_____ State:_____

Home Phone:_____ Birth Date: ____/____/_____

Cell Phone:_____ Social Security Number: _____

Email Address:_____ Primary Care Physician: _____

Phone Number of PCP:_____ How did you hear about us? _____

Do you have or are current experiencing any of the following? Check all that apply:

Eye History

☐ Glaucoma	☐ Floating Specs	☐ Previous Eye Injury
☐ Cataracts	☐ Flashing Lights	☐ Previous Eye Surgery
☐ Macular Degeneration	☐ Burning or tearing	☐ Double Vision
☐ Prior Retinal Detachment	☐ Sandy or Gritty feeling	☐ Strabismus (Crossed Eyes)
☐ Color Blindness	☐ Redness	☐ Other (List Below)
☐ Glare/Light Sensitivity	☐ Eye Pain or Soreness	☐ _____

Family History

☐ Diabetes	☐ High Blood Pressure	☐ Glaucoma
☐ Blindness	☐ Heart Disease	☐ Cataract
☐ Crossed Eyes	☐ Cancer	☐ Macular Degeneration

General Health Questions

☐ Fever	☐ Seizures	☐ Chronic Bronchitis
☐ Weight loss	☐ Headaches	☐ Wheezing
☐ Currently Pregnant	☐ High Blood Pressure	☐ Shortness of Breath
☐ Thyroid Problems	☐ Chest Pains	☐ Kidney Stones
☐ Diabetes	☐ Heart Disease	☐ Autoimmune Disease
☐ Deafness	☐ Previous Heart Attack	☐ HIV/AIDS
☐ Osteoarthritis	☐ High Cholesterol	☐ Depression
☐ Rheumatoid Arthritis	☐ Anemia	☐ Panic Attacks
☐ Osteoporosis	☐ Cancer	☐ Anxiety
☐ Previous-Stroke	☐ Asthma	☐ Other _____

Please Read: Please be advised that the patient is responsible for providing a current copy of his/her insurance cards and Photo ID. Your photo ID is important to protect against medical identity theft. The patient is also responsible for obtaining and providing a referral when required by the insurance company. Without the required information it will be the responsibility of the patient to pay for the services rendered on the day of the visit. Please be aware that Medicare and many other health insurance companies will not cover charges for items which may include, but are not limited to, refractions or medical supplies, which may be a part of your eye examination. Healthcare regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud. Non-covered service fees and co-payments are DUE AT TIME SERVICES ARE RENDERED.

_____ _____

Signature of Patient OR Guardian (if patient is a minor) **Date**

Medication List

Name:_____

Date of Birth:_____

Pharmacy:_____

Pharmacy Phone Number: _____

Allergies:_____

_____

Recent Surgeries:_____

_____

☐ I am currently not taking any medication

Date:_____

Medication	Dosage	Reason for Use