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

Patient Name_____ Date_____
Address:_____ City:_____State:_____
Cell Phone:_____ _____ Medical Doctor:_____
Date of Birth:_____

Name of Person Responsible if Patient is a Minor: DOB of Person Responsible:
_____ _____

**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 file 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**:_____

**Medication List**

Pharmacy: _____

Pharmacy Phone Number:_____

Surgeries:_____

Allergies:_____

_____

☐ I am currently not taking any medication

| Medication | Dosage | Reason for Use |
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