Patient Medical History

Patient Name _____Date of Birth _____

Referring Provider (Ex. Optometrist): _____

Primary Care Physician: _____

Mark all medical diagnosis that apply to you (past and present):

☐ High Blood Pressure	☐ Congestive Heart Failure	☐ COPD
☐ High Cholesterol	☐ Heart Attack	☐ Emphysema
☐ Irregular Heart Beat	☐ Stroke	☐ Asthma
☐ Diabetes – Type I	☐ Kidney Disease	☐ Seizures
☐ Diabetes – Type II	☐ Chronic Renal Failure	☐ Dementia
☐ Thyroid Disease	☐ Depression	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Lupus	☐ Cancer — Type(s): _____
☐ Bleeding Disorder	☐ BPH (Enlarged Prostate)	

Additional Medical Conditions:_____

Mark all OCULAR or GENERAL surgeries you've had:

Surgery	**Year**	**Surgery**	Year
☐ Retinal Surgery	_____	☐ Laser Eye Surgery	_____
☐ Cataract Surgery	_____	☐ Eyelid Surgery	_____
☐ Glaucoma Surgery	_____	☐ Eye Muscle Surgery	_____
☐ Corneal Surgery	_____	☐ LASIK	_____

Procedure	Year	**Procedure**	Year
☐ Brain Aneurysm Repair	_____	☐ Heart Bypass	_____
☐ Brain Tumor Removal	_____	☐ Heart Valve	_____
☐ Brain Shunt	_____	☐ Pacemaker	_____
☐ Pituitary Surgery	_____	☐ AAA Repair	_____
☐ Heart Stent	_____	☐ Melanoma Excision	_____
☐ Gastric Bypass	_____	☐ Splenectomy	_____
☐ Amputation	_____		

Patient Medical History

Please list additional surgeries & dates below:

_____

_____

Preferred Pharmacy (Name & Location): _____

Medications

List all current medications you are taking (Please Include all over-the-counter, herbals, vitamins, mineral supplements, dietary supplements).

Name:	Dose:	Frequency:

If medications exceed space provided, please attach a list.

Do you have any ALLERGIES TO Medications? ☐ Yes ☐ No

If yes, please list them below:

Medication:	Reaction:

Patient Medical History

Do you have any <u>family</u> history of any of the following conditions?

Label family members, Example: Mother, Brother, Child, Uncle, Grandmother

Condition	Who	Condition	Who
☐ Blindness	_____	☐ Cancer	_____
☐ Diabetes	_____	☐ Retinal Detachment	_____
☐ Stroke	_____	☐ Retinal Tear	_____
☐ Macular Degeneration	_____	☐ Glaucoma	_____
☐ High Blood Pressure	_____	☐ Heart Disease	_____
☐ Seizures	_____	☐ Autoimmune Disease, Type:_____	_____

Please answer the following about smoking & alcohol use, and falls history

Smoking Status	**Details**	
☐ Current Smoker	How many packs per day?	_____
☐ Former Smoker	When did you quit?	_____
☐ Never Smoked	Any current or former issues with substance abuse?	☐ Yes ☐ No

Other Questions:	**Response**	**Additional Details**
Do you currently drink any alcohol?	☐ 1–2 Daily ☐ 3–4 Daily ☐ Occasionally ☐ Never	
Have you had any falls in the past year?	☐ No ☐ Yes	If yes, how many falls? _____
Did you sustain any injury from prior falls?	☐ No ☐ Yes	

General Consent to Treat

Name: _____ DOB: _____

I consent and authorize the doctors of VRA Vision to
(1) discuss, document and securely store my health history/information and
(2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan.

I understand that some preliminary information gathering and basic testing done in the office is often performed by a member of my doctor's staff as well as by the doctor himself and this routine work-up often includes the instill of eye drops for various reasons - such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students/nurses/nurse aides, technicians and agents and employees of VRA Vision providing services to the patient.

I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient decides whether to follow those recommendations or not. The consent given here DOES NOT extend to initiation of any oral or IV medication nor any surgical procedures, injections or lasers performed whether in the office or at a surgical facility. Separate consent must be obtained for any of these procedures.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT OR BY LAW TO SIGN ON THE PATIENT'S BEHALF.

Patient Printed Name:_____ **Date:**_____

Patient Signature (or legal representative): _____

Patient Financial & Communication Policies

Patient Name: _____ **Date of Birth:** _____

The following are internal policies set in place by VRA Vision. Signature is required before services can be provided. VRA Vision is unable to accept any revisions to this form and any attempted changes shall be null and void.

Assignment of Benefits: You hereby assign to VRA Vision all your rights and claims for reimbursement under your health insurance policy. You agree to provide information as needed to establish my eligibility for such benefits.

Insurance Information and Filing: Our practice participates with many insurance plans across the region; however, *it is your responsibility to verify your benefits and coverage before services are rendered*. Your insurance carrier can confirm whether our clinic is considered in-network or out-of-network for your specific plan. For plans with which we are not contracted, you are responsible for any portion of the charges not covered by your insurer. If you are unable to pay your balance in full, you must make payment arrangements with our billing department before receiving additional non-emergency services.

To ensure accurate and timely processing of your claims, it is your responsibility to:

- Provide proof of active and valid insurance coverage and notify our clinic of any changes to coverage.
- Understand your insurance benefits, including your deductible, copayments, coinsurance, and network coverage.
- Confirm whether your plan requires a referral to see a specialist.
- Determine whether pre-authorization or pre-certification is required for tests, procedures, or surgery.
- Notify our office immediately of any changes to your insurance plan, policy number, coverage status, or demographic information.

Please note that failure to follow your plan's requirements may result in denied claims. Any resulting balances will be your financial responsibility.

If our provider is in-network with your insurance plan, we will provide all necessary information to your insurance plan to facilitate payment. If your insurance plan determines that a service is not covered, you agree to be responsible for the balance of that service, as permitted by applicable law and insurance contracts.

If our provider is out-of-network with your insurance plan, we will submit a claim to your insurance plan for services rendered as a courtesy. **However, your health insurance is a contract between you and your insurer.** You agree to be responsible for any portion of the service costs that is not reimbursed by your plan. Insurance benefits should be paid directly to the Practice. If your insurance plan issues reimbursement directly to you for services provided by our clinic, you must remit that payment to us within 10 days.

Co-payments, Co-insurance, & Deductible: These amounts, when known, may be due at the time of service prior to seeing the clinician. You understand and agree that you will be responsible for all legal fees and other costs of collection if your account is turned over to an agency for collection in which case your visit(s) with our office may become a matter of public record.

Outstanding Debt: If your account has open balances past due 120+ days, you will be required to pay the outstanding balance in full prior to your scheduled appointment. VRA Vision has the right to apply the down payment to any outstanding balance or bad debt balance first and may cancel any non-emergent appointments until the balance is settled. Repeated failure to keep payment arrangements may result in dismissal from the practice. This provision does not apply to patients who currently have Medicaid health insurance coverage or to patients who have filed for bankruptcy.

VRA Vision offers a short-term in-house payment plan and two third-party financing options: Cherry and CareCredit. Please speak to our billing team for more information.

Medicaid Affidavit (ALL patients must answer):

At this time I represent and warrant that the patient ☐ DOES or ☐ DOES NOT have Medicaid coverage. *(**Check one** – if unmarked, default is a representation that the patient does not have Medicaid currently. If you are completing this form on a system where you cannot circle one, please inform the staff immediately if the patient has Medicaid health insurance coverage).*

If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office, you may be responsible for the balance of your bill. Not all locations and clinicians participate in Medicaid programs. The patient will be responsible for the full amount of services provided when this circumstance is applicable.

Medicaid recipients MUST have a referral from the Primary Care Physician for the appointment to be eligible for reimbursement.

Uninsured Patients must pay the estimated cost of service in full prior to seeing a clinician on the date of service. Final charges will be determined after the clinician sees the patient and a complete assessment is made.

Procedure Pricing: I understand that procedure estimates are provided in writing through the Good Faith Estimate (GFE). Estimates must be requested prior to the appointment unless otherwise required by law.

Notice of payment processing fees for credit cards: For payments made by credit card, there may be a fee of the transaction amount that will be applied to cover merchant processing costs. You will be notified before the transaction of this fee, if any.

No-show and late-cancellations (Effective 1/1/2026):

1. Office appointments: Consecutive, repeated no shows and cancellations made within 24 hours will be assessed a $35 fee.
2. Surgeries: A no-show or cancellation within 2 business days will be assessed a $100 fee.

Patient Communications: In VRA Vision's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) you have provided to VRA Vision or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such messages may include, without limitation, reminders of upcoming scheduled appointments, information regarding test results, billing information, or answers to medical questions you may have inquired about to our staff. VRA Vision may also communicate with you via e-mail, text message, or postal mail to your home address provided such method complies with applicable HIPAA communication standards. Confidential information will be treated in accordance with HIPAA and applicable state law.

You specifically authorize and give your express consent to receive auto-dialed and/or pre-recorded calls – including voice and short message service (SMS) text messages and other electronic messages – from, or on behalf of, VRA Vision and its representatives at the number(s) provided or an appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, and billing and collection information. You understand that by providing your telephone number and/or e-mail address to VRA Vision, you consent to being contacted using the above-described methods. If you receive communications from VRA Vision, you will be given the opportunity to opt-out of future communications by responding "STOP" or another easily used mechanism, should you make that choice.

Research: You authorize VRA Vision to contact you regarding any research study in which you may be eligible to participate relating to my care.

The undersigned hereby agrees to these terms as the patient or legal representative of the above referenced patient if the patient does not have the legal capacity to agree (for example: minors under the age of 18 or incapacitated patients with an active power of attorney).

Patient or Legal Representative Signature: _____

Date : _____

Notice of Privacy Practices Acknowledgement of Receipt

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of VitreoRetinal Alliance, PLLC d/b/a VRA Vision. Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Please note that VRA Vision may communicate with you in the following ways, unless you instruct us otherwise:

- In VRA Vision's discretion, information of a confidential nature may be left on your voicemail or answering machine at the number(s) provided to our office or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such messages may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff. These communication policies shall apply to the phone numbers and email addresses you provide to VRA Vision staff for the above state purpose.

- VRA Vision may also communicate with you via e-mail, text message, or mail to your home address provided such method complies with applicable HIPAA communication standards. I understand the risks of communication by unencrypted email and SMS text.
- You specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls – including voice and short message service (SMS) text messages and other electronic messages – from, or on behalf of, VRA Vision and its representatives at the number(s) provided above or on appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, billing and collection information and marketing or advertising messages offering products or services that may be of interest to you. VRA Vision may receive direct or indirect payment for these marketing messages. You understand that by providing your telephone number and/or e-mail address to VRA Vision, you consent to being contracted using the above-described methods. If you receive communications from VRA Vision, you will be given the opportunity to opt-out of future communications by responding "STOP" or through another easily used mechanism, should you make that choice. You understand that you are not required to sign this agreement in order to receive treatment and that your consent is not a condition of purchasing or using any services offered by VRA Vision.
- If you have any questions about our Notice, please contact our HIPAA Privacy Officer at 605-401-6963 or privacy@vravision.com.
- Information Exchange: By signing this form you are opting in to VRA Vision's ability to participate in and share information with health information exchanges (HIEs). A Health Information Exchange is a secure system that allows doctors, hospitals, and other healthcare providers to share your health information electronically. HIEs help your healthcare team by giving your doctors a complete picture of your health, ensuring they have the right information at the right time. Protecting your privacy is a top priority. HIEs use strict security measures to keep your data safe. If you desire to opt out of participation, email your request to privacy@vravision.com.
- I hereby acknowledge receipt of VRA Vision's Notice of Privacy Practices and understand and agree to how VRA Vision may communicate regarding the patient; I do so as the patient or legal representative of the above referenced patient of the patient does not have the legal capacity to acknowledge (for example: minors under the age of 18 (19 in the state of Alabama) or incapacitated patients with an active power of attorney).

_____ _____

Patient or Legal Representative Signature **Date**

_____

Relationship to Patient

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's legal representative.

Reasons why the acknowledgement was not obtained:

- ☐ Patient or legal representative refused to sign this Acknowledgement even though the patient or legal representative was asked to do so and the Notice of Privacy Practices were made available.
- ☐ Other _____

_____ _____

Employee Name Date

Patient Information

Patient Name: _____Preferred Name:_____

SSN: _____DOB: _____Gender: ☐Female ☐ Male

Street Address: _____

City:_____State:_____Zip: _____

Home Phone: _____Mobile: _____

Email: _____

Occupation:_____

EMERGENCY CONTACT

Emergency Contact Name: _____Relationship: _____

Phone Number 1: _____Phone Number 2: _____

IF PATIENT IS A MINOR RESPONSIBLE PARTY/BILLING INFORMATION

Mother's Name: _____DOB: _____

Address: _____City: _____State: _____ZIP: _____

Cell Phone: _____ Home: _____

Father's Name: _____DOB: _____

Address: _____City: _____State: _____Zip: _____

Cell Phone: _____Home Phone: _____

PLEASE INCLUDE / SUPPLY INSURANCE CARDS TO SCAN INTO OUR SYSTEM.