317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

Patient Name:_____ Date of Birth:_____ SS#:_____
Gender: ☐ Male ☐ Female Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Zi/Hir
Email:_____ Cell:_____
Address:_____ City:_____ State:_____ Zip:_____

MEDICAL insurance? ☐ EyeMed ☐ NVA ☐ VBA ☐ VSP ☐ Other ☐ None
Name of Primary: _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Parent
Primary's DOB: _____ Member ID: _____ Primary's SS Number :_____

VISION insurance? ☐ Aetna ☐ BCBS ☐ Medicare ☐ Cigna ☐ UHC ☐ Other ☐ None
Name of Primary: _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Parent
Primary's DOB: _____ Member ID: _____ Primary's SS Number: _____

Vision History

When was your last eye exam? _____
Name of previous doctor: _____
Do you wear eyeglasses? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
If yes, what type: _____
Do you sleep in your contacts?: ☐ Yes ☐ No
Do you use eye drops?: ☐ Yes ☐ No
Have you ever had eye surgery? ☐ Yes ☐ No
What kind? _____

Medical History

List of medications:
_____
_____
_____
Allergies to medications:
_____
Primary Care Physician Name:
_____
Specialist Name: _____

Have you or a blood relative had any of the following:

Blindness	☐ Self	☐ Relative		Arthritis	☐ Self	☐ Relative	
Cataracts	☐ Self	☐ Relative		Asthma	☐ Self	☐ Relative	
Cross Eye	☐ Self	☐ Relative		Blood/Lymph Nodes	☐ Self	☐ Relative	
Glaucoma	☐ Self	☐ Relative		Cancer	☐ Self	☐ Relative	
Headaches	☐ Self	☐ Relative		Psychiatric	☐ Self	☐ Relative	
Amblyopia (Lazy Eye)	☐ Self	☐ Relative		Diabetes	☐ Self	☐ Relative	
Retinal Disease	☐ Self	☐ Relative		Ear/Nose/Throat	☐ Self	☐ Relative	
Eye Injury/Trauma	☐ Self	☐ Relative		Heart Problems	☐ Self	☐ Relative	
Eye Infections	☐ Self	☐ Relative		High Blood Pressure	☐ Self	☐ Relative	
Double Vision	☐ Self	☐ Relative		Seizures	☐ Self	☐ Relative	
Flashes/Floaters	☐ Self	☐ Relative		Digestion Issues	☐ Self	☐ Relative	
Macular Degeneration	☐ Self	☐ Relative		Thyroid	☐ Self	☐ Relative	
Dry Eye	☐ Self	☐ Relative		Elevated Cholesterol	☐ Self	☐ Relative	
Iritis	☐ Self	☐ Relative		Multiple Sclerosis	☐ Self	☐ Relative	
Diabetic Retinopathy	☐ Self	☐ Relative		Respiratory	☐ Self	☐ Relative	
Optic Nerve Disease	☐ Self	☐ Relative		Urinary/STD	☐ Self	☐ Relative	

Social History

Smoke? ☐ Yes ☐ No	**Pregnant/Nursing?** ☐ Yes ☐ No
Drink? ☐ Yes ☐ No	**Blood transfusion?** ☐ Yes ☐ No

317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

Office Policies

Examinations and Office Visits: Dr. Amy Farrall is committed to providing you and your family with excellent eye care.Each patient has different eye care needs. If you have any questions regarding recommended treatments and insurance coverage, please contact your insurance company. Insurance company recommendations are generalized guidelines and may not be appropriate to your individual case.

Appointment Scheduling: It is customary for a medical practice to require at least **24 hour** notice in advance to cancel or reschedule an appointment. Canceling with less notice inconveniences other patients who need eye care. Any patient who misses an appointment without 24 hours notice will be subject to a **$35 fee**.

Participating vs. Nonparticipating Providers: Please ask if we participate with your insurance carrier **before** you receive treatment. A listing of insurance companies with which we participate is located on our website. **Whether we participate with your insurance company or not, payment is due in full at the time of service.** You are responsible for understanding your insurance company's policies regarding referrals, payments, coverage, etc. Your medical insurance is a contract between you and your insurance company. All charges are your responsibility from the date the service is rendered regardless of insurance coverage. This contract is between Vision Center of Delaware and you, and supersedes any agreement you may have with your insurance company.

Insurance Cards and Vouchers: Any insurance card, voucher, or referral must be presented at the time of service. We cannot bill retroactively with information presented after your visit.

Medical Referrals: You are responsible for obtaining all necessary referrals for testing and office visits as required by your medical insurance company. The Vision Center of Delaware is unable to guarantee benefits or authorizations.

Eyeglasses: We would like to fabricate your eyeglasses as needed. When placing your order, a 50% deposit is required.No glasses may be taken from the office unless all account balances are paid in full. One time courtesy redo with no refunds. We do not bill medical insurance companies for glasses. (Exceptions: NVA, VBA, VSP, Eyemed, Superior Vision). If you choose to utilize your own frames not purchased at the time of your visit, VCD along with its eyeglass laboratories, are not responsible for any damages that occur to the frame while in our possession. **Once fabrication of your glasses order has started, deposits are non-refundable and glasses are non-returnable. PD measurements are NOT a part of your prescription.There is a $35 charge.**

Contact Lens Wearers: Professional fees associated with the fitting and measuring of contact lenses are not covered by medical insurance policies and are NOT part of the comprehensive eye examination. We do not bill medical insurance companies for lenses, fittings and evaluations. (Exceptions: NVA, VBA, VSP, Eyemed, Superior Vision, or medically necessary contact lenses). When placing your order, a 50% deposit is required. **Contact lens prescriptions are only good for 1 year by DE state law. It is our office policy that all contact lens wearers have a yearly eye exam to have their contact lens prescription updated.**

Payments: We accept **cash, bank checks, Visa, Mastercard, Discover, American Express, Care Credit, and Apple Pay**. Payments for non-covered services and co-payments are due at the time services are rendered. Post-dated or third party checks are not accepted. Effective immediately **Medicare and most Medical Insurances will not pay for refraction** patients will be responsible for a **$45 refraction fee.**

Past Due Outstanding Balances: We reserve the right to withhold any ordered materials, prescriptions or medical information until any and all outstanding balances are paid in full. All accounts with a balance outstanding beyond 60 days are handled by an independent collections agency. The patient will be responsible to pay the collection agency fee of 55% of balance and/or court and attorney fees.

Returned checks: Accounts will be charged an additional **$50.00 fee** for all returned checks. You will be notified by phone and mail. If the account is not paid in full within 10 days of receiving our phone call/letter, the account will be handled by an independent collections agency. The patient will be responsible to pay all outstanding fees associated with any returned checks.

Medical Records: If for any reason you wish to have your medical records forwarded to another practitioner, we will need a signed records release form.

I have read and understand all the above stated policies.

Signature: _____ Date: _____

317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

Explanation of Medical and Routine Exams

We are often asked about the difference between **medical** and **routine** eye exams. Both medical and routine eye exams may include the same components such as:

- Refraction **(which may or may not be covered by certain medical insurances)**
- Dilation
- Intraocular Pressure Testing
- A personal examination by an eye care professional
- Completion by either an **optometrist** or **ophthalmologist**

The primary difference in **medical** and **routine exams** is often determined by insurance providers based on **chief complaints** or the physician's **findings and/or diagnosis**.

- A **medical exam** includes diagnosis and treatment of an eye disease or malady *(glaucoma, macular degeneration, diabetic retinopathy, conjunctivitis, or cataracts)*
- A **routine eye exam** includes diagnosis and treatment of non-medical complaints *(astigmatism, hypermetropia/farsightedness, myopia/nearsightedness, presbyopia)*

******IT IS NOT A CHOICE OF THE PATIENT WHETHER OR NOT THEY ARE BILLED AS A COMPREHENSIVE EXAM OR A MEDICAL EXAM. THIS DECISION IS MADE BASED ON THE FINDINGS OF THE DOCTOR.***

What is an EOB?

An explanation of benefits *(commonly referred to as an **EOB form**)* is a statement sent by your health insurance provider describing what costs will be covered for the medical care or products you've received. The EOB is generated when your provider submits a claim for the services you received. The insurance company sends you EOBs to help make clear:

- **The cost of the care you received**
- **Any money you saved by visiting in-network providers**
- **Any out-of-pocket medical expenses you'll be responsible for**

I, _____, acknowledge that I have viewed and am aware of the **"Explanation of Medical and Routine Exams/ What is an EOB?"** for the office of Dr. Amy M. Farrall, O.D.

Signature: _____ Date: _____

317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed: _____

This consent was signed by:_____

(PRINT NAME PLEASE)

Signature:_____ Date:_____

317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

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

Request release TO/FROM:

(Physician, Facility) _____
(Street Address)_____
(City/State/Zip code) _____
(P) _____ (F) _____

Request release TO/FROM:

Vision Center of Delaware
317 E. Main Street
Newark, Delaware 19711
(P) 302.737.5777 (F) 302.737.0142

Please release medical record information for family members listed below:

Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____

RECORDS RELEASE: I hereby authorize you to release to me, at the above address, any information including the ocular and refractive diagnosis, pertinent findings, and records of any treatment from this patient's/family's most recent visit(s) to your office. Thank you for your prompt attention to this request.

_____ _____
Name of Patient or Authorized Representative Date

_____
Signature of Patient or Authorized Representative

317 E. Main Street
Newark, DE 19711
302.737-5777 302.737-0142

VISION CENTER OF DELAWARE

Amy M. Farrall, O.D.

MEDICARE PATIENTS ONLY!
Advance Beneficiary Notice of Noncoverage (ABN)

Note: If Medicare doesn't pay for the services listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health provider have good reason to think you need. We expect Medicare may not pay for the services listed below:

SERVICES	REASON MEDICARE MAY NOT PAY	FEE
Refraction *(determines eyeglass prescription)*	**Medicare does not cover it because this is a routine exam or screening procedure done in conjunction with a routine exam.**	**$45**
Professional services *(co-insurance /deductible amounts)*	**Medicare covers up to 80% of services after Medicare deductible has been met. If there is no secondary insurance, the patient is responsible for the remaining balance.**	**Varies**

What you need to do now:

-Read this notice, so that you can make an informed decision about your care.
-Ask us any questions that you may have after you finish reading.

We may ask to be paid now, but we will also bill Medicare for an official decision on payment, which is sent to you on a Medicare Summary Notice (MSN). **Please understand that if Medicare doesn't pay, you are responsible for payment,** but you can appeal to Medicare by following the directions on the MSN. If Medicare does pay, we will refund any payments made to us, less copays or deductibles.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/ **TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also request a copy for your records.

Signature: _____ Date: _____