Dr. Joseph J. Timmes, Jr., M.D.

3301 Woodburn Road, Suite #204
Annandale, VA 22003
Phone: (703) 560-7797
Web: www.NoVaRetina.com

EYE HISTORY

Name: ____ **Date:** ____________________

Thank you for choosing our office for your eyecare. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ YES ☐ NO
2. Do you wear contact lenses? ☐ YES ☐ NO
3. Do you have problems reading? ☐ YES ☐ NO
4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye pain	Blurred Vision	Eyelid Crusting	Flashes of Light	Halos
Discharge	Light Sensitivity	Double Vision	Decreased Vision	Floaters

5. Have you ever had an eye injury? Please describe: ______________________________________
____
____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:
____________________________________ R/L ____________________________________
____________________________________ R/L ____________________________________
7. Are you currently using any eye medications? Please list name and how often used: ____________
____
____

8. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes	Heart Disease	High Blood Pressure
Stroke	Arthritis	Other: ______________________________

9. What medications other than above are you taking? Please list: __________________________
____
____

10. Are you allergic to any medications? Please list: ______________________________________
____
____

11. Do you have any family history of eye problems? Please circle and list family relationship:

Glaucoma	Cataract	Retinal Disease	Macular Degeneration

12. Please circle any of the following that you would like more information about:

Radial Keratotomy	Contact Lenses	Cataract Surgery
Diabetic Eye Disease	Glaucoma	Other: ______________________________

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing the Consent form, you agree to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made. Joseph J. Timmes, Jr., M.D. FACS Ltd. "Practice" provides this form to comply with the Health Insurance Portability & Accountability Act of 1996. (HIPAA)

The patient understands that:

- ✓ **Protected health information may be disclosed or used for treatment, payment or health care operations; this includes billing Medicare and/or private insurance companies for payment and using your health information to obtain payment.**
- ✓ **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a copy if so desired.**
- ✓ **The Practice reserves the right to change the Notice of Privacy Policies**
- ✓ **The patient ahs the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.**
- ✓ **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- ✓ **The Practice may condition treatment upon the execution or non-execution of this Consent.**

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FROM THE OFFICE OF JOSEPH J. TIMMES, JR., M.D. TO OUR NEW PATIENTS

WELCOME TO OUR PRACTICE! WE ARE DEDICATED TO PROVIDING YOU WITH QUALITY OPHTHALMOLOGICAL CARE.

PLEASE KEEP THE FOLLOWING INFORMATION FOR YOUR RECORDS:

IF WE ARE NOT A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY, IN ORDER TO CONTROL OVERHEAD COSTS AND SIMPLIFY OUR BILLING PROCESS, THE FOLLOWING IS REQUIRED:

1) **PAYMENT FOR NON-SURGICAL SERVICES IS DUE AT THE TIME THOSE SERVICES ARE RENDERED**
2) **PAYMENT FOR SURGICAL SERVICES IS DUE WIITHIN 60 DAYS OF THE DATE OF SURGERY**

IF WE ARE A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY, IN ORDER TO CONTROL OVERHEAD COSTS AND SIMPLIFY OUR BILLING PROCESS, THE FOLLOWING IS REQIRED:

1) **IF YOU HAVE A FIXED COPAY FOR OFFICE VISITS AND/OR SURGICAL PROCEDURES, PLEASE PAY THAT AMOUNT AT THE TIME OF SERVICE.** ***(YOU SHOULD KNOW WHAT THAT AMOUNT IS BY ITS LISTING ON THE FRONT OF YOUR INSURANCE CARD OR WITHIN YOUR INSURANCE DOCUMETATION, GIVEN TO YOU BY YOUR INSURANCE COMPANY AND/OR YOUR EMPLOYER.)***
2) **PLEASE BE AWARE THAT COPAYMENTS MAY BE HIGHER AT THE BEGINNING OF EACH CALENDER YEAR.**

BILLED COPAYMENTS AND DEDUCTABLES ARE DUE THIRTY (30) DAYS FROM THE DATE YOU RECEIVE OUR FIRST BILL

WE ACCEPT THE FOLLOWING METHODS OF PAYMENT FOR YOUR CONVENIENCE:

VISA
MASTERCARD
CASH
CHECK

OUR OFFICE WILL SUBMIT ALL MEDICARE CLAIMS DIRECTLY TO MEDICARE FOR ALL SERVICES. IN ADDITION, OUR OFFICE WILL SUBMIT ALL CLAIMS TO YOUR INSURANCE COMPANY, IF WE ARE A CONTRACTED PROVIDER WITH THEM. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER, WE WILL GIVE YOU A COMPLETED INSURANCE CLAIM FORM FOR YOU TO SUBMIT YOURSELF FOR REIMBURSMENT.

IN ORDER TO CLARIFY MEDICAL INSURANCE REIMBURSEMENT PROCEDURES, PLEASE UNDERSTAND THE FOLLOWING:

1) **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, IF APPLICABLE, AND THE INSURANCE CARRIER. WE ARE NOT A PARTY TO THAT CONTRACT UNLESS WE PARTICIPATE WITH YOUR SPECIFIC INSURANCE CARRIER.**
2) **OUR FEES ARE GENERALLY CONSIDERED TO FALL WITHIN THE ACCEPTABLE RANGE BY MOST INSURANCE COMPANIES.**
3) **NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS, HOWEVER, SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES FOR WHICH THEY WILL NOT REIMBURSE-BUT THIS IS A RARE OCCURANCE.**
4) **IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL, YOU MUST HAVE THAT REFERRAL IN ORDER TO BE SEEN OR OUR OFFICE MUST HAVE THE REFERRAL PRIOR TO YOUR VISIT.**
5) **IN GENERAL, OUR PRACTICE PARTICIPATES WITH MOST PPOS, BUT ONLY IN SOME INSTANCES, DO WE PARTICIPATE WITH HMOS, EPOS, OR POS. (IF YOU ARE UNSURE IF YOU HAVE ANY OF THOSE ABOVE MENTIONED, PLEASE SEE A MEMBER OF OUR OFFICE STAFF)**

ALL OF THE ABOVE MENTIONED IS YOUR RESPONSIBILITY TO KNOW, AS WELL AS FOR OUR MUTUAL BENEFIT

AS A MEDICAL PRACTICE, OUR RELATIONSHIP IS WITH YOU, OUR PATIENT, NOT YOUR INSURANCE CARRIER (UNLESS WE PARTICIPATE WITH YOUR INSURANCE COMPANY). WE REALIZE THAT FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR BILL. IF SUCH PROBLEMS ARISE, PLEASE CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT.

IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION OR ANY UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK US. WE ARE HERE TO HELP YOU.

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PATIENT MEDICAL HISTORY

PLEASE DESCRIBE THE REASON FOR TODAY'S VISIT: ____________________
____

HAVE YOU EVER HAD ANY PROBLEMS WITH YOUR EYES IN THE PAST (E.G. INFECTIONS, INJURIES, OR OPERATIONS)? IF SO, PLEASE DESCRIBE:
____
____

DO YOU WEAR GLASSES OR CONTACT LENSES NOW? YES NO

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS? (E.G. DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE OR EMPHYSEMA)
____
____

PLEASE LIST YOUR CURRENT MEDICATIONS:

1________________________ 6________________________
2________________________ 7________________________
3________________________ 8________________________
4________________________ 9________________________
5________________________ 10________________________

ARE YOU ALLERGIC TO ANY FOOD OR MEDICATION?
IF YES, PLEASE STATE WHAT IT IS AND THE REACTION THAT FOLLOWS:
____
____

HAVE YOU EVER HAD ANY MAJOR SURGERIES OR OPERATIONS? PLEASE LIST BELOW AND WHEN YOU HAD IT:

1____
2____
3____

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PATIENT'S AUTHORIZATION

I, ____, hereby authorize
PRINT YOUR NAME

Joseph J. Timmes, Jr., M.D., F.A.C.S., Ltd. to apply for benefits for covered services rendered by him, from: Medicare, BCBS, AARP, or any other insurance that you are covered by

_________________________________.
PRINT YOUR INSURANCE CARRIER

I certify that the information I have reported with regard to my insurance is correct and further **authorize the release of any necessary information**, including medical information for this or any related claim to Medicare, BCBS, AARP and/or any other insurance that you have:

______________________________________.
PRINT YOUR INSURANCE CARRIER

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

Please list your primary insurance carrier:_________________________

Secondary insurance carrier, if applicable:_________________________

Third insurance, if applicable: _________________________________

____ ________________
SUBSCRIBER SIGNATURE DATE

IF YOU ARE NOT THE SUBSCRIBER, PLEASE PRINT THE SUBSCRIBER'S NAME AND DATE OF BIRTH BELOW:

____

____

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To Our New Patients:

Welcome to our practice. We are dedicated to providing you with quality ophthalmological care.

The following payment information should be retained for your records:

Unless we are a participating provider with your insurance company, in order to control overhead costs and simplify the billing process, payment for nonsurgical services is due at the time services are rendered. We accept payment by check, cash, MasterCard, or Visa. Payment in full for surgical services is due within 60 days of the date of surgery. If we are a participating provider with your insurance company and you have a fixed co-payment for office visits and/or surgical procedures, please pay your co-payment at the time the services are rendered.

We will give you a completed insurance claim form to forward to your insurance company for reimbursement in connection with any nonsurgical services. Insurance claims for surgical services performed either in the office or at the hospital will be submitted directly to your insurance company. In addition, for our Medicare beneficiaries, we submit claim forms directly to Medicare for all professional services.

In order to clarify medical insurance reimbursement procedures, please understand the following:

1. Your insurance policy is a contract between you, your employer, if applicable, and the insurance company. We are not a party to that contract unless we participate with your specific insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and, therefore, are covered up to or close to the maximum allowance determined by each insurance carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services for which they will not reimburse.

As a medical practice, our relationship is with you, our patient, not with your insurance company. While the completion of insurance claim forms is a courtesy that we extend to you, charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your bill. If such problems do arise, please contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

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INITIAL

______I have read and/or received a copy of the Notice of Privacy Practices (HIPAA) and I agree to the treatment and health care options described within.

______I have read and/or received a copy of the Practice office letter (regarding payment and insurance).

This consent was signed by:

____
Patient/Patient Representative

Relationship to patient (if other than patient)

____

Date:___________________________

Witnessed in front of:

____

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REGISTRATION FORM

DATE_________________

FULL LEGAL NAME: ____ Sr. Jr. III.

ADDRESS____

CITY_______________________ **STATE**______________ **ZIP**__________________

HOME PHONE_______________________ **WORK PHONE**___________________

DATE OF BIRTH_______________**SEX**____**AGE**_____**MARITAL STATUS**_____

PATIENT'S SOCIAL SECURITY#____

REFERRING DOCTOR_____________________**TELEPHONE#**________________
CURRENT OPTOMOTRIST/OPHTHAL: _____________________________________
FAMILY DOCTOR__________________________TELEPHONE#_________________

WHO TO NOTIFY IN CASE OF EMERGENCY_____________________________

TELEPHONE#________________**RELATIONSHIP TO PATIENT**: _____________

ADDRESS:
____

INSURANCE INFORMATION:

*IF PATIENT'S INSURANCE IS UNDER ANOTHER NAME, PLEASE GIVE NAME & D.O.B. OF SUBSCRIBER: ____

EMPLOYMENT INFORMATION:

EMPLOYER__________________________OCCUPATION______________________

ADDRESS________________________________TEL. #_________________________

SPOUSE'S
EMPLOYER____________________________OCCUPATION________________________

ADDRESS___________________________________TEL. #___________________________