Craig G. Hoover, O.D.
& Associates, PLLC

Address: 691 Laurel Street, Suite 100
Culpeper, VA 22701

Phone: (540) 825 - 0541
Fax: (540) 829 – 5823

Patient Information

Patient name: _____
First name Middle name Last name

Social Security Number: __ __ __ - __ __ - __ __ __ __

Date of Birth: _____ / _____ / _____
Month Day Year

Address: Street: _____ City: _____

_____ State: _____ Zip+4: _____ - _____

Phone: Home: _____ Work: _____ Mobile: _____

Employer: _____ **Occupation:** _____

Vision Ins. Carrier: _____ **Medical Ins. Carrier:** _____

Family Doctor: _____ _____

Financial Information and statements:

Payment for professional services is expected on the date of service. Please provide all insurance information (**medical and/or vision**) prior to your visit so that any participation insurance claims can be processed without delay.

If you are not prepared for payment of co-payments and/or professional services, please inform the office staff prior to services being rendered.

Initial: _____

Cancellation and No-Show Policy

We require 24 hours notice for appointment cancellations. We understand that there are circumstances that may not allow you to keep your appointment. However, our office does not "double book" appointments and your appointment time is reserved specifically for you. Our policy is (1) missed appointment without charge. Any additional missed appointments will be subject to $25.00 charge per occurrence.

Initial: _____

Past Due Accounts

Account balances over 30 days will be subject to a finance charge of 1.5% monthly (18% annually). Minimum monthly finance charge is $1.00.

Account balances over 90 days will be subject to collection procedures which may include, but are not limited to, transfer to a collections agency and/or warrant of debt procedures.

Initial: _____

Office policy acknowledgement

I have read and agree to abide by the policies above.

Signature: _____ **Date:** _____
Patient or authorized person's signature

Authorization of Insurance Benefits and Financial Responsibility Statement

I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of benefits to Craig G. Hoover, O.D. and Associates, PLLC for any services rendered or materials provided.

I understand that I am financially responsible for all charges for services and materials provided to me, including any balance remaining after payment of possible insurance benefits.

Signature: _____ **Date:** _____
Patient or authorized person's signature

Printed: _____
Printed name of authorized person

This form continues on the next page.

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It is our mission to provide the highest level of care and services to our patients. Please review the following information and notices that will guide you through the various aspects of your care and services.

Professional Services

A **routine eye exam** is performed to determine the need for corrective lenses and includes a routine check of the health of the eyes. Vision insurance coverage applies to this type of visit.

A **medical eye exam / office visit** is performed to diagnose, evaluate, treat or monitor the health of the eyes with respect to a specific complaints or medical conditions. Since the exam or office visit involves a medical condition, it may be submitted to your medical insurance for coverage whether or not you have vision coverage. The fees for this type of service vary depending on the complexity of care provided.

A **refraction** is the testing used to determine a prescription for glasses. This service is considered routine and is included as part of a routine exam but is considered a separate procedure when performed as part of a medical exam / visit.

A **contact lens fit / yearly evaluation** is a separate service performed to determine an appropriate contact lens prescription and is in addition to an exam. Fees for the additional testing and evaluation vary depending on complexity of the services necessary to complete the fit or yearly evaluation.

Professional services may include both medical and routine services. Strictly medical services will be billed to your medical insurance and will be subject to co-payments, co-insurance, deductibles and any applicable referral requirements as specified by your policy. Strictly routine services will be billed to your vision insurance. When medical and routine services are performed on the same date (Example: Medical visit/exam with a refraction), services will be submitted to your medical insurance. Coordination of benefits for any routine service(s) provided will be dependent on your insurance carrier and benefit plan.

Some common reasons for a medical evaluation may include but are not limited to:

- Blurred vision
- Eye injuries, allergies and infections
- History of floaters
- History of diabetes or hypertension
- Previous diagnosis of a medical eye condition that requires continued monitoring.
- Previous diagnosis of a systemic medical condition that can have ocular manifestations.
- Use of medications that can have potential ocular side effects.

Ancillary testing services

Ancillary tests are performed to aid in diagnosis and/or treatment of a medical condition. Some examples of this type of service include Retinal photography, Ocular coherence tomography, Gonioscopy, Pachymetry and Visual field testing. These tests are often covered by your medical insurance subject to separate co-payments, co-insurance and deductibles the policy provisions regarding ancillary testing.

Important notes:

- It is not always possible to determine if a symptom (example: blurred vision) is the result of a vision problem (the need for glasses) or a medical condition (cataracts, macular degeneration, etc.), until after the exam has begun.
- Our office may assist in obtaining information about your benefits but it is the patient's responsibility to know and understand participation and eligibility before services are rendered.
- Your insurance company makes the final determination of benefits. Any benefits information that our office obtains is for information purposes only and does not guarantee coverage.

Optical Services

All work/orders require a minimum deposit of 50% to order with the balance due upon delivery.

If you have any questions or concerns discuss them with our staff or office manager prior to services being rendered.

I acknowledge that I have reviewed the above notices.

Signature: _____ **Date:** _____

Patient or authorized person's signature