NEW PATIENT PAPERWORK/INFORMATION

Welcome to Wink Eyecare!

Our office located at 1095 Seven Locks Road, Potomac, MD 20854. We are inside the Potomac Woods shopping Center, next to Brooklyn's Deli and Quincy's Restarurant. Our phone number is (301) 545-1111. Please feel free to call us with any questions or concerns.

Some things to keep in mind:

- Please complete all New Patient Paperwork and bring send it back before your appointment. If you cannot complete this prior to your appointment, we ask that you arrive 15 minutes early to do so in our office.
- If you normally wear contact lenses, please have them in for at least **2 hours prior** to your appointment. Please provide any contact lens information as well: RX, brand, etc. Send it via text to 301-545-1111. Please also bring any glasses that you currently use.
- Please bring a copy of your medical insurance card or text it to 301-545-1111 If your exam results in a medical diagnosis, we may be able to bill your medical insurance on your behalf for part of the exam. You will be responsible for your Specialist Copay, the Refraction ($50.00) is normally not covered depends on the insurance, and any additional tests.
- We are a provider for VSP, Vision Service Plan. This plan requires pre-authorization. If you are a VSP member, please call and notify us ahead of time. We can then pull your authorization and let you know the details about your benefits and allowances.
- Please call us if you can't make/need to reschedule your appointment. We do have a Cancellation/No-Show Policy. We require 24 hours' notice to change an appointment, to avoid a $80 charge. Thanks in advance for your consideration and your courtesy.

We look forward to seeing you soon! At Wink Eyecare we are committed to you and your eyes. We always want you to look and see your best!

Dr. Rachel Cohn
and your Wink Eyecare Team

CONSENT OF TREATMENT, BILLING, AND NOTICE OF PRIVACY PRACTICES
WINK EYECARE BOUTIQUE,LLC

1095 Seven Locks Road, Potomac, MD 20854

I, the undersigned, authorize Wink Eyecare Boutique, LLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third party payers and other health practitioners involved in my care. I authorize and request my insurance company to pay directly to Wink Eyecare Boutique, LLC all insurance benefits otherwise payable to me for services rendered. I understand that my eye care or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Service charges of 1 1/2 % per month will be added to all balances over 60 days past due. In the event it becomes necessary to collect a balance through litigation or a collection agency, I agree to pay all collection fees, and attorney's fees incurred. I further authorize the use of this signature on all insurance submissions

NOTICE OF PRIVACY PRACTICES

HIPAA Privacy Officer: Dr. Rachel Cohn, OD

Effective Date: May 16, 2006

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We are committed to maintaining the privacy of your protected health information ("PHI"). We are legally required to record information about your health condition and the care and treatment you receive here, and this record-keeping is critical to your safety. This Notice details how your PHI may be used and disclosed to third parties. It also reviews your rights regarding your PHI.

Our records are electronic and can be accessed only by the doctor and staff via password entry. We do not send records by email without encrypting them to prevent their being read by parties other than the intended recipient. You have the right to see the records that we keep about your care.

We may disclose your PHI to other parties, without a separate consent for its release, in the following situations: 1) to other doctors and health care providers who are already treating you with your consent, or to whom you are being referred as part of our explicit plans (you will know when this is going to occur);
2) to third party payors (e.g. Medicare or your insurance company) in order for you to receive the coverage benefits that pay for your care; 3) to various third parties who are monitoring the quality of the care you receive, as required by law; and 4) to our business associates such as billing services.

The Practice may also disclose your PHI, without a written Consent from you, in the following additional instances: 1) De-identified information that does not identify you and, even without your name, cannot be used to identify you; 2) To a business associate if we obtain satisfactory written assurance, that they will appropriately safeguard your PHI; 3) To a person who, under applicable law, has the authority to represent you in making decisions related to your health care; 4) for the purpose of obtaining or rendering emergency treatment; 5) To a government authority if the Practice is required by law to make such disclosure regarding physical abuse or neglect; 6) To agencies charged with Health Oversight Activities, as required by law, including criminal investigations; 7) In response to a court order or a lawfully issued subpoena;
8) to a law enforcement official under certain circumstances; 9) To a coroner or medical examiner for the purpose of identifying you or determining your cause of death; 10) To an entity to whom you have agreed to donate your organs; 11) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public (to an individual who is reasonably able to prevent or lessen the threat); 12) To the Workers' Compensation system.

X_____ Patient's Date of Birth _____

Signature of Patient or Parent

X_____ Date _____

Printed Name of Patient or Parent

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Cell Phone _____
Alt Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Date of Birth _____Age _____

Email Address _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Social Media
- ❑Bethesda Magazine
- ❑ Web Page: Which Web Site? _____
- ❑ Other _____

At Wink Eye Care we are committed to provide the highest quality eye care by combining advanced technology with current industry trends so that you may always look and see your best.

Insurance Information

Please note that NOT all insurances cover the Contact Lens Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber ID #_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber ID#_____
Subscriber Birth Date_____

EMAIL OR TEXT FRONT AND BACK OF CARD TO WINK

Do you participate in a flex spending account?
❑ Yes ❑ No

Lifestyle Questions

Do you……(check box if your answer is yes)
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..have interest in a "test drive" of the latest contact lens designs
- ❑..spend time outdoors? How much? __Hrs/week
- ❑..have prescription sunwear?
- ❑..prefer not to wear your glasses at times?
- ❑..want information on Laser Vision Correction surgery?
- ❑..have interest in a non-surgical approach to vision correction?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have children?
- ❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable glasses	

❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

- ❑ Allergies
- ❑ Arthritis
- ❑ Blood/Lymph
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cholesterol
- ❑ Diabetes
- ❑ Digestive
- ❑ Ears/Nose/Throat
- ❑ Endocrine
- ❑ Eczema/Rashes
- ❑ Fatigue
- ❑ Fevers
- ❑ Genitourinary
- ❑ High Blood Pressure
- ❑ Integamentory (Skin)
- ❑ Kidney
- ❑ Muscle/Bone
- ❑ Neurological
- ❑ Psychological
- ❑ Respiratory
- ❑ Sinus
- ❑ Throat Infections
- ❑ Thyroid
- ❑ Unusual weight losses/gains

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used:_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Wink Eyecare.

By signing below, I authorize Wink Eyecare to keep my signature and my credit card information securely on-file in my account. I authorize Wink Eyecare to charge my credit card for any outstanding balances when due.

Please enter your credit card number and expiration date.

CC#:_____ CVV_____ Expiration Date:_____

Signature:_____

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