Wagoner Family Eye Care, PLLC

R. Luke Wagoner, O.D.
3701 B Old Forest Rd
Lynchburg, VA 24501
434-385-0213

Patient No _____

********** Patient Registration **********

Today's Date: _____ Patient Name: _____
Birthdate: _____ Patient Soc Sec: _____
Marital Status (Choose One) Single ____ Married ___ Divorced ___ Widowed ___ Separated ____
Patient Address: _____
Patient Phone: _____ Patient Cell Phone: _____
Texting Ok (Circle One)? Yes or No
Patient Email Address: _____
Patient Employer: _____ Patient Work Phone: _____

********** Emergency Contact **********

Emergency Contact Name:_____
Emergency Contact Address: _____
City _____ State _____ Zipcode _____
Emergency Contact Phone Number: _____

**********Guarantor Information **********

Guarantor Name: _____

Guarantor Address: _____

If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement.

Signature_____ Date _____

********** Insurance Assignment **********

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Wagoner Family Eye Care, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. Please be advised that if you are using insurance coverage for your visit, this is a contract between you and your insurance company .... not our office. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Wagoner Family Eye Care may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian or Personal Representative **Date**

_____ _____
Print Name of Patient, Guardian or Personal Representative **Relationship to Patient**

********** Cancellation/ No Show **********
Late Arrival Policy - $24/ 24 hr.

We care about you, your eye health, and your time. Therefore, as a courtesy to us and all of our patients, please contact us to reschedule your appointment within 24 hours of your appointed time, or a $24 charge will be assessed.

Signature_____ Date _____

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********** Patient Consent **********

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule" was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As a patient of Wagoner Family Eye Care, PLLC we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we think are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

The release of information to other family members needs to be authorized in writing by the patient before disclosure of treatment results or health information is released. Wagoner Family Eye Care, PLLC will not be responsible for individuals posing as or impersonating someone else when requesting results via the phone.

We may at times have an indirect treatment relationship concerning you, for example, with laboratories that relay information directly to the physician and not the patients. These entities do not require a separate patient consent although personal health care information will need to be disclosed for appropriate care.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this must be done in writing to the Privacy Officer, Wagoner Family Eye Care, PLLC, 3701B Old Forest Road, Lynchburg, VA 24501

Under this law we have the right to refuse to treat you should you refuse to disclose your PHI. If you choose to give consent in this document, at some further time you may request to refuse all or part of your PHI from being disclosed. You may not revoke actions that have already been taken which relied on this or a previous signed consent.

A copy of Wagoner Family Eye Care, PLLC's privacy notice is available to review at all times during regular business hours.

I consent to the use or disclosure of my protected health or vision information by Wagoner Family Eye Care, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wagoner Family Eye Care, PLLC. I understand that diagnoses or treatment of me by Wagoner Family Eye Care, PLLC may be conditioned upon my consent as evidenced by my signature on this document. I also acknowledge my receipt of the Notice of Privacy Practices.

Print Name_____ **Date** _____

Signature_____

I authorize the following person to access to my health information:

_____ Relationship _____

********** Payment **********

I UNDERSTAND THAT PAYMENT IS EXPECTED ON THE DATE OF SERVICE (INCLUDING ALL CO-PAYS AND DEDUCTIBLES) UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Signature_____ Date _____

********** New Patients **********

Who may we thank for referring you to our office or how did you hear about Wagoner Family Eye Care? _____

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