a wink & a smile

Visual Field Testing

During a routine eye exam, it is recommended that patients have a visual field test to assess the potential presence of blind spots, which could indicate eye diseases. A blind spot in the field of vision can be linked to a variety of specific eye diseases, depending on the size and shape of the blind spot.

Many eye and brain disorders can cause visual field abnormalities. Examples of this include: optic nerve damage caused by glaucoma, optic nerve damage from disease, toxic exposure or damage to the retina (the light-sensitive inner lining of the eye). Additionally, visual field testing can reveal brain abnormalities caused by strokes and tumors.

Visual Field Tests are not covered by vision insurances, but are still highly recommended, especially for patients over the age of forty.

☐ Yes, I authorize the administration of the Visual Field Test today. **The fee for this test is $60.00**. I accept financial responsibility for this additional vision test.

☐ No, I would prefer not to have the Visual Field Test at this time.

Print Name: ____

Signature: ___________________________ Date: _____________

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PATIENT REGISTRATION

First Name: ______________________________ Last Name: ______________________________ Middle Initial: ____

Preferred / Nickname: ____________________________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date: ______________________ Soc Sec: _____________________

Address: _______________________________________ Address 2: _______________________________________

City: _______________________________________ State: _________ Zip:____________________

Home Phone: ___________________ Work: ___________________ Ext: ________ Cellular: ___________________

E-mail: ____ *(appointment-related correspondences)*

Employer: ____ O Full time O Part Time ORetired O Student

Policy Holder / Parent / Guardian *(If different from patient)*

First Name: ______________________________ Last Name: ______________________________ Middle Initial: ____

Birth Date: ______________________ Soc Sec: _____________________ Drivers Lic: ________________________

O Mark if address is same as above

Address: _______________________________________ Address 2: _______________________________________

City: _______________________________________ State: _________ Zip:____________________

Home Phone: ___________________ Work: ___________________ Ext: ________ Cellular: ___________________

E-mail: ____ Employment Status: O Full time O Part Time O Retired

Insurance Information

Primary Insurance *(Please provide card if available)* – Please supply as much information as possible.

Name of Insured: ____________________________ Insured is: O Patient O Spouse O Parent O Other

*Insured ID #: ________________________ Insured Birth Date: ___________________

Employer: _______________________________ Insur. Company: _____________________________

City,State,Zip:____________________________ Address: ___________________________________

Group Number: ___________________________ City,State,Zip: _______________________________

**Required (social security or member ID)*

Secondary Insurance *(If applicable - please provide card if available)*

Name of Insured: ____________________________ Insured is: O Patient O Spouse O Parent O Other

Insured ID #: ________________________ Insured Birth Date: ___________________

Employer: _______________________________ Insur. Company: _____________________________

City,State,Zip:____________________________ Address: ___________________________________

Group Number: ___________________________ City,State,Zip: _______________________________

Referred by: O **Mailer** O **Insurance** O **Patient:** ____________________ O **Other:** __________________

Previous Doctor: _______________________ City,State: _______________________ Phone: __________________

Emergency Contact: ___________________________ Phone: _______________ Relationship: ________________

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Patient Name: ______________________ Date of Birth: ____________ Date: ____________

MEDICAL HISTORY

Question			
Are you under a physician's care now?	☐ No	☐ Yes	If yes: ______________________
Have you ever been hospitalized or had a major operation?	☐ No	☐ Yes	If yes: ______________________
Have you ever had a serious head or neck injury?	☐ No	☐ Yes	If yes: ______________________
Are you taking any medications, pills, or drugs?	☐ No	☐ Yes	If yes: ______________________
Do you take or have you taken Phen-Fen or Redux?	☐ No	☐ Yes	If yes: ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ No	☐ Yes	If yes: ______________________
Are you on a special diet?	☐ No	☐ Yes	If yes: ______________________
Do you use tobacco?	☐ No	☐ Yes	If yes: ______________________

WOMEN: Are you… ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine Drugs ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ Yes: ____________ Do you use controlled substances? ☐ No ☐ Yes If yes: ____________

Do you have or have you had any of the following:

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◻ Yes ◻ No	Cortisone Medicine	◻ Yes ◻ No	Hepatitis A	◻ Yes ◻ No	Recent Weight Loss	◻ Yes ◻ No
Alzheimer's Disease	◻ Yes ◻ No	Diabetes	◻ Yes ◻ No	Hepatitis B or C	◻ Yes ◻ No	Renal Dialysis	◻ Yes ◻ No
Anaphylaxis	◻ Yes ◻ No	Drug Addiction	◻ Yes ◻ No	Herpes	◻ Yes ◻ No	Rheumatic Fever	◻ Yes ◻ No
Anemia	◻ Yes ◻ No	Easily Winded	◻ Yes ◻ No	High Blood Pressure	◻ Yes ◻ No	Rheumatism	◻ Yes ◻ No
Angina	◻ Yes ◻ No	Emphysema	◻ Yes ◻ No	High Cholesterol	◻ Yes ◻ No	Scarlet Fever	◻ Yes ◻ No
Arthritis/Gout	◻ Yes ◻ No	Epilepsy or Seizure	◻ Yes ◻ No	Hives or Rash	◻ Yes ◻ No	Shingles	◻ Yes ◻ No
Artificial Heart Valve	◻ Yes ◻ No	Excessive Bleeding	◻ Yes ◻ No	Hypoglycemia	◻ Yes ◻ No	Sickle Cell Disease	◻ Yes ◻ No
Artificial Joint	◻ Yes ◻ No	Excessive Thirst	◻ Yes ◻ No	Irregular Heartbeat	◻ Yes ◻ No	Sinus Trouble	◻ Yes ◻ No
Asthma	◻ Yes ◻ No	Fainting Spells/Dizziness	◻ Yes ◻ No	Kidney Problems	◻ Yes ◻ No	Spina Bifida	◻ Yes ◻ No
Blood Disease	◻ Yes ◻ No	Frequent Cough	◻ Yes ◻ No	Leukemia	◻ Yes ◻ No	Stomach/Intestinal Disease	◻ Yes ◻ No
Blood Transfusion	◻ Yes ◻ No	Frequent Diarrhea	◻ Yes ◻ No	Liver Disease	◻ Yes ◻ No	Stroke	◻ Yes ◻ No
Breathing Problems	◻ Yes ◻ No	Genital Herpes	◻ Yes ◻ No	Low Blood Pressure	◻ Yes ◻ No	Swelling of Limbs	◻ Yes ◻ No
Bruise Easily	◻ Yes ◻ No	Glaucoma	◻ Yes ◻ No	Lung Disease	◻ Yes ◻ No	Thyroid Disease	◻ Yes ◻ No
Cancer	◻ Yes ◻ No	Hay Fever	◻ Yes ◻ No	Mitral Valve Prolapse	◻ Yes ◻ No	Tonsillitis	◻ Yes ◻ No
Chemotherapy	◻ Yes ◻ No	Heart Attack/Failure	◻ Yes ◻ No	Osteoporosis	◻ Yes ◻ No	Tuberculosis	◻ Yes ◻ No
Chest Pains	◻ Yes ◻ No	Heart Murmur	◻ Yes ◻ No	Pain in Jaw Joints	◻ Yes ◻ No	Tumors or Growths	◻ Yes ◻ No
Cold Sores/Fever Blisters	◻ Yes ◻ No	Heart Pacemaker	◻ Yes ◻ No	Parathyroid Disease	◻ Yes ◻ No	Ulcers	◻ Yes ◻ No
Congenital Heart Disorder	◻ Yes ◻ No	Heart Trouble/Disease	◻ Yes ◻ No	Psychiatric Care	◻ Yes ◻ No	Venereal Disease	◻ Yes ◻ No
Convulsions	◻ Yes ◻ No	Hemophilia	◻ Yes ◻ No	Radiation Treatments	◻ Yes ◻ No	Yellow Jaundice	◻ Yes ◻ No

Have you ever had any serious illness not listed above? ◻ Yes ◻ No Comments: ______________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of ANY changes in medical status.

Signature of Patient, Parent, or Guardian:

X ______________________________ **Date:** ____________

Financial Policy & Receipt of Privacy Practices

It is our policy at a wink & a smile to provide all of our patients and customers with quality care. We will bill your insurance as a courtesy to you. We accept most PPO insurance plans and this is required as part of our contract with the insurance company. We do not accept any discount plans, HMO or DMO plans. Upon completion of treatment we will submit your claim. You will be responsible for your estimated portion on the date of your visit.

We give all of our patients an estimate of cost prior to completing treatment. In some cases, this is written and in some cases it is verbal. We do our very best to estimate your insurance payment to be as accurate as possible. Our estimates are based on information provided to us by your insurance company. Your payment may vary from the estimate provided to you by our office if there is a restriction, declaration, or clause in your insurance contract.

Please understand that the insurance policy is a contract between you and the insurance company. We will verify your insurance eligibility as a courtesy, **but it is your responsibility to know and understand your coverage**. Any service completed at a wink & a smile is your complete financial responsibility. We will file all primary and secondary insurance claims. Any balance on the account is due upon receipt of the statement. Any late or unpaid invoices/statements will be charged interest and late fees. If your account becomes past due (over 90 days) and we require a Collections Attorney, you will be liable for all fees associated with the Attorney, court costs, late fees and interest. Please keep in mind, these fees can be very expensive and will affect your credit.

_______ ***Scheduling:*** Dental appointments are normally one hour visits, with longer appointments for more extensive treatment. Your reservation requires the presence of a doctor, an assistant, and, in some cases, a hygienist. **We require a minimum of 2 business days' notice if you need to reschedule your visit.**

_______ As a courtesy, a wink & a smile will remind you of your upcoming appointment via Smile Reminder. Patients will receive automated phone calls, text messages, and emails to remind and confirm appointments previously made by the patient or authorized party on behalf of the patient. If at any time you or an authorized party chooses to opt-out of this service, you will be responsible for keeping all reserved appointments and **will not** receive communication from our office. Should you miss or cancel an appointment without 2 business days' notice, for any reason, you will be charged a failed reservation fee.

Short notice cancellation and failed reservation fees start at $100 for hygiene appointments and $150 for appointments with the doctor.

By signing this document, I agree to the Financial Policy of a wink & a smile and understand it is subject to change without notice.

SIGNED: ____ DATE: _________________________

Patient's Name: ___________________________________ Relationship to Patient: _____________

ACKNOWLEDGEMENT OF RECEIPT (Please see the attached laminated copy)

I acknowledge that I received a copy of Notice of Privacy Practices. A personal copy of this document can be made available to you at your request.

SIGNED: ____ DATE: _________________________

Patient's Name: ___________________________________ Relationship to Patient: _____________

Return Policy

For Prescription Eyewear Patients:
At a wink & a smile, our optometrist(s) will perform a complete and thorough eye exam resulting in the best prescription to fit your needs. In the unlikely event that your prescription is slightly off, or you are otherwise unhappy with the lenses that have been placed in your chosen frames, the optical laboratory will redo your prescription lenses once within the first thirty (30) days after the receipt of your frame, free of charge. Any issues brought to our attention after the first thirty days will not be covered by the lab or our office. After the initial thirty day period, the expense for replacing the lenses will be the patient's responsibility. Frames cannot be returned once they have left the office. If there is a manufacturing defect, we can often use the warranty to replace them with the exact same model within one year of your purchase.

Our staff will do our best to dispense our patients' new prescription eyewear in a timely manner. However, under certain insurance policies, we are unable to use our preferred lab and have no control over the amount of time it takes to receive your eyewear. We are able to give rough estimates of the time it will take to receive your eyewear, however, we will not be able to offer a refund in the event it takes the lab longer than expected to return your eyewear. You will receive notifications your eyewear is ready via email or text. Should you opt-out of this option, it is your responsibility to check the status of your eyewear.

For Contact Lens Patients:
Most insurance plans allow for the use of benefits for either contact lens exams with a supply of lenses **or** frames and lenses. Please be sure to maintain the follow-ups recommended by the doctor. In the event that more than thirty (30) days has passed since the initial contact lens fitting, a new exam and contact lens fitting may be needed and the cost of these services will be the responsibility of the patient. Should the patient is not able to adapt to contact lenses and wishes to use their benefits for glasses instead, they will be responsible for the contact lens exam fitting fee which is a separate charge from the standard eye health exam. **If you have any questions about this, please address your concerns before the exam.** The contact lens exam fee represents services already rendered and is non-refundable. There are no refunds on contacts since they are designed to specifically fit your eyes.

Waiver for lens replacement in USED frames:
a wink & a smile always strives to return eyeglasses in excellent condition. In some cases, older glasses could have damaged or stressed areas that could cause breakage during lens replacement. Due to this condition, we cannot be responsible for any defects that could result from prior damage or normal wear and tear.

_____ We are more than happy to adjust your glasses to best suit you. a wink & a smile is not responsible for any damage caused to frames not purchased in our office within the last year.

By signing this document, I agree to the Return Policy of a wink & a smile and understand it is subject to change without notice.

SIGNED: ____ DATE: ________________________

Patient's Name: ___________________________________ Relationship to Patient: _____________

a wink & a smile

20745 Williamsport Place, Suite 120

Ashburn, VA 20147

571.333.1250

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME: ____

I authorize the professional office of a wink & a smile to release health information identifying me, including- if applicable, information about HIV infection or AIDS, information about substance abuse and/or-treatment, and information about mental health under the following terms and conditions:

1. Detailed description of the information to be released**: a wink & a smile ONLY releases treatment or related information to your insurance company.**

2. To person(s) identified by the patient:
   Name: ________________________________ Relationship to Patient: _______________
   Name: ________________________________ Relationship to Patient: _______________

3. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. a wink & a smile, however, cannot submit any claims to any insurance company should you refuse to sign which will result in full office fees due at the time of service for any completed treatment.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: ____ Date: _____________

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Print Name: _________________________________ Relationship to Patient: ____________________