Name:
Chart:
Date:

NORTHERN VIRGINIA OPHTHALMOLOGY ASSOCIATES

PATIENT REGISTRATION

DATE _____ REFERRED BY _____

PLEASE PRINT FULL NAME

❑ MR. ❑ MS.
❑ MRS. ❑ DR.

PATIENT'S NAME _____ AGE _____ SEX _____ BIRTHDATE _____
FIRST MIDDLE LAST

ADDRESS _____ PHONE (H) _____
STREET CITY STATE ZIP

EMPLOYER _____ OCCUPATION _____ PHONE (W) _____

PRIMARY CARE PHYSICIAN NAME: _____ PHONE: _____

EMERGENCY CONTACT: NAME: _____ PHONE: _____ REL: _____

Please print your email address: _____ **Last 4 digits of SSN: XXX-XX-**

Please answer the following questions about your medical history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
   ❑ YES ❑ NO If YES, please explain: _____

2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   ❑ YES ❑ NO If YES, please explain: _____

3. Have you ever had any surgery? ❑ YES ❑ NO If YES, please explain: _____

4. Do you take any medications? ❑ YES ❑ NO If YES, please list: _____

5. Do you have any drug allergies? ❑ YES ❑ NO If YES, please list drug and nature of reaction: _____

6. Have you had any of the following problems?

	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑	
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	❑	❑	
Heart problems (e.g., chest pain, irregular heartbeat)	❑	❑	
Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis)	❑	❑	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	❑	❑	
Urinary problems (e.g., pain or discomfort, bladder infections)	❑	❑	
Skin disease (e.g., rashes, eczema, dermatitis)	❑	❑	
Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints)	❑	❑	
Neurologic problems (e.g., numbness weakness, paralysis, headache)	❑	❑	
Psychiatric problems (e.g., depression anxiety)	❑	❑	

7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
   ❑ YES ❑ NO If YES, please explain: _____

8. Do you smoke? ❑ YES ❑ NO, how much?_____ drink alcohol? ❑ YES ❑ NO, how much?_____

   Smoking Start Date: _____ **Smoking End Date:** _____

   Or, age started smoking: _____ ***Or, age quit smoking:*** _____

❑ Reviewed by (Dr. Signature) _____ Date _____

Name:
Chart:
Date:

MEANINGFUL USE DEMOGRAPHICS FORM

Why do we ask our patients about their race, ethnicity, and preferred language?

We have recently begun to ask our patients to identify their race, ethnicity and preferred language. If you are uncomfortable answering these questions, you should feel free to decline to answer, and we will not ask you again.

The federal government is promoting adoption of electronic health records, and one of their requirements for "meaningful use" of electronic health records is the ability to collect information about the race and ethnicity of our patients to measure and minimize care disparities based on these characteristics.

Extensive scientific research shows that disparities in the quality and outcomes of health care correlate with patients' race and ethnicity. The Health Resources and Services Administration defines these health disparities as "population-specific differences in the presence of disease, health outcomes, or access to health care." Recent new studies indicate that the first step toward addressing health disparities involves collecting this type of data and linking this information to health care quality, safety, and utilization.

Please circle one answer for each category or check box at bottom to decline:

Race Choices

African American/Black
American Indian
Asian
Native Hawaiian
White
Other

Ethnicity Choices

Hispanic/Latino Origin
Non-Hispanic/Non-Latino Origin
Other

Language Choices

Arabic
Armenian
Chinese
English
French / Creole
German
Greek
Gujarati
Hebrew
Hindi
Italian
Japanese
Korean
Persian
Polish
Portuguese
Russian
Spanish
Tagalog
Urdu
Vietnamese
Yiddish
Other

☐ **Decline to answer**

Name: Age:
Chart:
Date:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have access to your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my health information. I understand that *Northern Virginia Ophthalmology Associates* ("NVOA") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand that NVOA is not required to agree to my requested restrictions, but if agreed upon, then NVOA is bound to abide by such restrictions.

Name of patient	Patient/guardian signature	Date

AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to the above Acknowledgement Form. The patient may desire other individuals such as family members to have access to their PHI. Use the spaces below to specify those individuals, their relationship to you, and any limitations (if any) on the extent of their access to your PHI (e.g. billing issues only), and any expiration date to that access. **Please list parent(s) name(s) if patient is a minor.**

Name	Relationship	Limitations/Expiration Date

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Name of patient	Patient/guardian signature	Date

Name:
Chart:
Date:

ePrescribing Consent

Northern Virginia Ophthalmology is in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that Northern Virginia Ophthalmology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes**.**

Patient Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

PATIENT PORTAL AUTHORIZATION FORM

Northern Virginia Ophthalmology Associates now has a secure method for patients to contact our office staff: the Patient Portal. The Patient Portal provides secured communication between our patients and our office staff. The Portal can be used to request non-emergency appointments, appointment changes, and other medical information (such as glasses prescriptions and medical records). Patients can also view their Summaries of Care (information on their recent office visits) via the Portal. Our Portal is secure because it requires users to enter an email address and a unique password to access their information and messages.

At the end of your first appointment, if we have an email address on-file for you, you will automatically receive an invite to join our Patient Portal. Additionally, you may receive 1 - 2 emails prior to an appointment asking you to complete paperwork for your upcoming appointment online. You may also receive 1 - 2 emails following each appointment inviting you to log into the Patient Portal and view your Summary of Care document. However, at any time, you may choose to opt-out of participating in our Patient Portal. Patients who opt-out of participating in our Portal will no longer have access to online versions of their medical information and they will no longer have access to request appointments, re-schedules, and/or cancellations online. Additionally, as more features are added to the Portal, patients who opt-out of participating in the Portal will not have access to those features, either.

The quality and availability of care that we provide will not be impacted by a patient's decision to opt-in or opt-out of Patient Portal participation. Lastly, a patient may opt-in or opt-out of participating in our Patient Portal at any time by completing a new Patient Portal authorization form. However, any Portal communication that is already en route to you will not be able to be cancelled.

❒ **Opt-In:** I agree to the above terms and I agree to participate in the Northern Virginia Ophthalmology Associates Patient Portal:

Patient / Guardian Signature _____ Date _____

❒ **Opt-Out:** I do not agree to participate in the Northern Virginia Ophthalmology Associates Patient Portal.

Patient / Guardian Signature _____ Date _____

OFFICE USE ONLY

Date Portal account de-activated: _____

Employee Initials: _____

Name:
DOB:
Chart:
Date:
Survey Sent: ❒ _____
Prov / Doctible ID:

TEXT MESSAGE AND EMAIL AUTHORIZATION FORM

Northern Virginia Ophthalmology Associates now has the capability to text and email patients regarding past, present, and future appointments. By opting-in below, you will authorize our staff and/or third parties (business associates) acting on behalf of Northern Virginia Ophthalmology Associates to send you text messages and/or emails using the information you provide below. At no time will your email address or phone number be used to promote any services or products from Northern Virginia Ophthalmology Associates or our business associates. The nature of the text messages and emails that are sent to you may be related to **appointment reminders**, **scheduling reminders**, **scheduling updates**, **office hour updates**, **billing matters**, and **requests for feedback** on your completed appointments. **Electronic communications related to medical records and other matters will only be sent through our secure Patient Portal.**

Your selections and information on this form will remain valid unless another form is completed by you.

We will make every effort to ensure a secure delivery of text messages and emails to your chosen mobile phone number and/or email address. However, since these text messages and emails will not be encrypted, the communication sent from us or our business associates to you may be intercepted by a third party, including (but not limited to) individuals with access to your text messages and individuals with access to your email account. So, by opting-in to receive text messages and emails from us, should a communication that is sent to the provided phone number or email address be intercepted, you agree to absolve Northern Virginia Ophthalmology Associates and its employees and business associates of any responsibility for the interception.

Patients are not required to opt-in to receive text messages or emails from us. Additionally, the quality and availability of care that we provide will not be impacted by a patient's decision to opt-in or opt-out of receiving such communication.

Lastly, a patient may opt-in or opt-out of receiving electronic communications from Northern Virginia Ophthalmology Associates or our business associates who are acting on our behalf at any time by completing a new authorization form. However, any information that is already en route to the patient prior to processing an updated consent form may still be sent using the information provided below.

❒ **Opt-In:** I agree to the above terms and authorize Northern Virginia Ophthalmology Associates to send me **(check all that apply):**

❒ **Text messages to:** _____

❒ **Emails to:** _____

My preferred method of contact for electronic communications is (please only choose one):

❒ Text message ❒ Email

_____ _____
Patient / Guardian Signature Date

❒ **Opt-Out:** I do not authorize Northern Virginia Ophthalmology Associates to send me text messages and/or emails.

_____ _____
Patient / Guardian Signature Date