Eagle Eye Vision Center
Dr. Christina J. Dixon, OD, PC – Dr. Kevin L. Dixon, OD
120 Soaring Eagle Dr. Stafford, VA 22556
540-720-0407

Notice of Privacy Practices

I give this practice my consent to use or disclose my protected health information to carry out my treatment, and to obtain payment from insurance companies.

I have been informed that I may review the office's Notice of Privacy Practices (for more complete descriptions of uses and disclosures) before signing this consent.

I understand that the practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature ______________________________ Date ________________
(Patient, Parent or Legal Guardian)

Email ____

If signed by patient representative, state relationship to patient ________________________

Please list anyone that you wish for us to release your personal information with:

Name ______________________________ Relationship to Patient ________________

Name ______________________________ Relationship to Patient ________________

Name ______________________________ Relationship to Patient ________________

Dr. Christina J. Dixon, OD, PC – Dr. Kevin L. Dixon, OD

Patient Information Sheet

(Please Print)

Patient______________________________ Birthdate ____________ Age______ Sex M / F

Guardian______________________________ Relationship ____________

Home Phone #__________ Cell #__________ Work #__________ Patient SS#____–____–____

Address________________________ City ____________ State ____ Zip_____

Occupation____________________ Employer ____________________

Email______________________________________

VISION Insurance: Name____________________ Policy# ____________________

Name of Insured________________________ SS#____–____–____ Date of Birth_______

MEDICAL Insurance: Primary Ins. Name____________________ Policy# ________________

Name of Insured________________________ SS#____–____–____ Date of Birth_______

Previous Eye Doctor______________________________ Date of Last Exam __________

Primary Care Physician____________________ Phone#____________ Fax# ____________

Reason for Exam ______________________________________

Have you previously worn Glasses? Y / N If Yes, Distance Reading Bifocals Prism
Have you previously worn Contacts? Y / N If Yes, Soft Hard

Individual & Family Health History *(Circle what applies)*

Self
LASIK (year_____) Eye Disease Eye Surgery Amblyopia (Lazy Eye) Crossed Eyes
Eye injury Glaucoma Cataracts Blindness Macular Degeneration
Diabetes High Blood Pressure High Cholesterol Heart Disease

Other ______________________________________

Family *(State Who)*
Eye Disease ____________ Amblyopia (Lazy Eye) ____________
Crossed Eyes____________ Glaucoma ____________ Cataracts ____________
Blindness ____________ Macular Degeneration ____________
Diabetes____________ Heart Disease ____________
High Blood Pressure____________ High Cholesterol ____________

Other ______________________________________

Do you use Cigarettes or Tobacco? Y / N ______ Alcohol? Y / N ______ Other Substances? Y / N ______

List ANY MEDICATIONS that you are taking (Prescription, non-prescription, supplements)________________

____

List ANY/ALL ALLERGIES ________________________________

The information above is correct to the best of my knowledge. Please note it is not the responsibility of our office to determine your insurance benefits – Please know your plan benefits at the time of your appointment. I understand that I am responsible for payment of all services or materials provided to me. If I have insurance, and assignment is accepted by my doctor, I am responsible for any payments denied or not paid by my Insurance.

Signature______________________________ Date____________

Eagle Eye Vision Center
Dr. Christina J. Dixon, OD, PC – Dr. Kevin L. Dixon, OD
120 Soaring Eagle Dr. Stafford, VA 22556
540-720-0407

It is the goal of Dr. Dixon to provide you with the finest eye care available at a cost that is both fair and reasonable. Your understanding of our policies is essential.

Our office is not obligated to submit insurance forms for insurance plans we do not participate in. We will be happy to submit the claims for any insurance that we are a provider for but we do not submit to any secondary insurance. We will, however, provide you with the necessary information to submit the claim yourself.

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH THE CORRECT AND COMPLETE VISION AND MEDICAL INSURANCE INFORMATION WHICH INCLUDES THE SUBSCRIBERS NAME, DATE OF BIRTH, ADDRESS, IDENTIFICATION NUMBER, AND EMPLOYER. YOU MUST INFORM US OF ANY CHANGES PRIOR TO YOUR APPOINTMENT. WE CAN NOT FILE CLAIMS WITHOUT THIS INFORMATION.

INSURANCE PLANS

We participate with many insurance plans. Plan participation is subject to change. You should be aware that MEDICAL visits and ROUTINE EYE EXAMS are different. Your insurance may not be the same for both. You may be subject to different copays depending on your type of visit. You are responsible for your copays and any fees not covered by your insurance at the time of your visit. You are responsible for any referrals needed as well any deductibles, coinsurance or charges denied by your insurance. It is YOUR responsibility to know your insurance plan fees, rules, and guidelines. Any questions as to why your plan paid or denied a claim should be directed to your insurance company NOT our staff. We do try to keep up to date on the insurance plans but it is nearly impossible for our staff to be familiar with the requirements of all insurance plans.

If you are not covered by any insurance plan payment is expected at the time of service. We accept cash, check, Visa, and MasterCard.

CONTACT LENS POLICY

Contact lens exams are separate services and are not part of the routine eye exam. There is an additional fee for all exams that include a contact lens evaluation and /or prescription. Contact lens fees vary depending on the fit and type of contact lens needed. Contact lens fittings are good for 90 days; there will be a fee for any visits afterwards. The ONLY soft contact lenses our office fits are the disposable types. Our office fits some of the most premium contact lenses that may not be available at all the mass merchandise chains. If you have any concerns please let us know at the time of your visit. Contact lens prescriptions do expire in one year. A full eye exam and contact lens evaluation must be completed to renew the prescription.

Contact lenses are a medical device that sits on the eye. This can produce physiological changes to the eye as well as eye infections. If you experience any problems do not hesitate to call our office for an appointment or advice.

EYEGLASS POLICY

Eyeglasses are a custom order designed specifically for you. Therefore we are not able to offer refunds for orders already placed or completed. We do require at least 50% deposit when an order is placed and the full balance is due at the time of pick up. Copays and overages for your insurance plan are due in full when eyeglasses are ordered.

See Back

CANCELLATIONS
A 24 hour notice is REQUIRED for all cancelled appointments. Failure to do so will result in a $60.00 missed appointment charge and may also affect the scheduling of future appointments.

ALL RETURNED CHECKS ARE SUBJECT TO BANK CHARGES AND A RETURNED CHECK FEE OF $35.00. FUTURE CARE MAY BE ON A CASH BASIS ONLY.

YOUR ACCOUNT IS YOUR RESPONSIBILITY. IF YOUR ACCOUNT BECOMES PAST DUE FOR ANY REASON YOU MAY BE TURNED OVER TO A COLLECTION AGENCY. YOU ARE RESPONSIBLE FOR THE CHARGES INCURRED BY THE COLLECTION AGENCY.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

____ _______________________
Patient / Guardian's Signature Date

Email____

Eagle Eye Vision Center
Dr. Christina J. Dixon, OD, PC – Dr. Kevin L. Dixon, OD
120 Soaring Eagle Dr. Stafford, VA 22556
540-720-0407

In order for Eagle Eye Vision Center to continue to provide quality comprehensive eye care, we need to keep up to date with insurance, billing, and coding regulations. Please be advised we can no longer bill Commercial Vision Plans for Eye Health evaluations. In order to maintain proper exams, documentation, billing, and coding, be advised most patients will now need to use their Medical Insurance for their eye appointments.

Medical Eye Exam

- Comprehensive Eye Health Exam
- Billed towards your Medical Insurance, the same as any other health provider
- Specialist co-pays and deductibles apply, and are due at the time of service
- Patient is responsible for refraction, determining an eyeglass prescription
- Provides advice, assessment, and documentation of any conditions of the eye: Examples include – Diabetes, Cataracts, Glaucoma, Macular Degeneration, Dry Eyes, Red Eyes, Flashes, Floaters, Eye Pain, Injury, Retina Disease, Infection, Lazy Eye, Strabismus, Amblyopia, Allergies, Keratoconus, Blepharitis, etc

Commercial Vision Exam

- Routine Well Visit Vision Exam – this is NOT eye insurance
- Billed towards your Commercial Vision Plan
- Provides assessment of vision status only, such as: Nearsightedness, Farsightedness, Astigmatism
- If medical issues are found, you need to switch to your Medical Insurance or in some cases you may return for another appointment to have these assessed and documented

We are unable to bill medical insurance and commercial vision plans on the same day. However, you may use your medical insurance and vision material benefit on the same day. Please understand that in order for Eagle Eye Vision Center to continue to provide the best quality comprehensive eye care, we must adapt to proper billing and coding rules. This means that due to many health or ocular conditions many patients will no longer be able to be seen under their Commercial Vision Plan.

Patient Name ______________________________ Date ______________

Patient Signature ____

Other Family Member ______________________________________