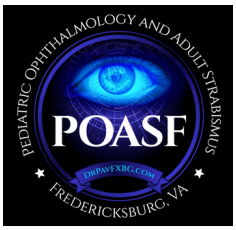


Pediatric Ophthalmology and Adult Strabismus of Fredericksburg

Joseph C. Paviglianiti, M.D.

Phone: 540.681.1211 Fax: 540.681.1544 email: Info@drpavfxbg.com Website: www.drpavfxbg.com

Patient Registration: (Please Print Clearly)

Patient Name _____

Date of Birth:_____Age:_____ Gender: (circle) Male/Female Race: _____

Student Status (Circle One): Full Part None Marital Status (if Applicable, circle) M S W D

Main Phone #:_____ Alternate Phone#:_____

Main Email:_____

Parent(s)/Guardian(s) Names:_____

Home Address: _____

Emergency Contact:_____Phone#_____

Primary Care Physician:_____ Physician Phone#_____

Pharmacy:_____ Pharmacy Phone#_____

Insurance/Self-Pay:

Primary Insurance: _____

Member ID#:_____Group #: _____

Policy Holder Name if Different than Patient: _____

Policy Holder DOB: _____Policy Holder SSN:_____

Secondary Insurance: (if applicable) _____

Member Id#: _____Group #:_____

Policy Holder Name if Different than Patient: _____

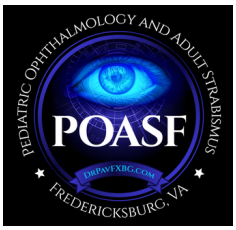
Policy Holder DOB: _____ Policy Holder SSN: _____

****IF Self-Pay:** Name of Responsible Party_____

Phone #:_____Address:_____

I understand that all financial responsibility, for any medical services provided to my child/myself by Pediatric Ophthalmology and Adult Strabismus of Fredericksburg will be mine if my insurance was not in effect on the date of services. I agree to pay all collection and/or attorney fees related to any medical services provided.

Parent/Legal Guardian/Patient Signature: _____**Date:** _____



PEDIATRIC OPHTHALMOLOGY AND ADULT STRABISMUS OF FREDERICKSBURG

JOSEPH C. PAVIGLIANITI, M.D.

HIPAA ACKNOWLEDGEMENT

Dear Valued Patient/Family of Patient of P.O.A.S.F.,

The United States government has passed a law that requires us to clearly identify guidelines for release of medical information. This law took effect April 14, 2003. The purpose of this law is to safeguard medical information from sources not authorized to possess this information and the same time to release appropriate information to other healthcare providers, insurance companies, and other authorized agencies. It is our goal and requirement that we use your medical information with confidentiality and our best judgement in any communication with your family and others. Pediatric Ophthalmology and Adult Strabismus of Fredericksburg is in compliance with Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

You have the right to request restrictions on the use and disclosure of your health information. You also have the right to inspect and/or copy your health information. We may charge a fee to cover time and resources copying medical records.

I understand the risks and give my permission to Dr. Joseph C. Paviglianiti at Pediatric Ophthalmology and Adult Strabismus of Fredericksburg (P.O.A.S.F.) to communicate with me via-email or text to include but not limited to my medical records and health information. Precautions will be taken to preserve the confidentiality of these communications between P.O.A.S.F. and patients, realizing that no digital communication is entirely risk-free.

An expanded document is available upon request, which covers these issues in greater detail. If you would like a copy of this document, please let our office staff know and it will be provided to you.

I have read and understand the information on this form.

Signature:_____Date:_____

(**a copy of your signature is valid as an original)

CONSENT TO SHARE MEDICAL INFORMATION:

I may choose to include additional persons whom I give permission to P.O.A.S.F. physicians and employees to share all medical information. The individuals whose names appear below will be saved in the patient's electronic medical identification record. I will update that list of names during my check-in at all visits, to include adding new persons or removing persons whom I no longer want to give permission to.

The following individuals have permission to access all protected medical information for my child:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I have read the above and understand my/my child's rights under HIPAA regulations. I hereby give permission and written consent to P.O.A.S.F. to share all medical information with persons listed in my HIPAA consent list.

Signature:_____Date:_____

(**a copy of your signature is valid as an original)

Pediatric Ophthalmology and Adult Strabismus of Fredericksburg

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Consent to Treat:

Child's name:_____Date of Birth:_____

Designated Adult(s) who may bring my child to an appointment, and consent to their treatment:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

Initial each line:

_____(initial) I understand that my authorization is given prior to any ocular treatment or recommendation. This authorization empowers Designated Adult(s) authority to exercise their best judgement upon the advice of Pediatric Ophthalmology, and consent to or refuse any eye care or treatment for my child.

_____(initial) I retain the responsibility for all financial obligations owed to Pediatric Ophthalmology and Adult Strabismus of Fredericksburg, resulting from Designated Adult(s) consent.

_____(initial) I give permission to Pediatric Ophthalmology and Adult Strabismus of Fredericksburg to bill my medical insurance with the understanding that any remaining charges or non-covered services are my responsibility.

_____(initial) I release Pediatric Ophthalmology and Adult Strabismus of Fredericksburg, it's Providers and Staff from any liability arising from this form and the named Designated Adult's consent to or refusal of treatment.

_____(initial) I understand that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State Laws govern the disclosure of Protected Health Information (PHI). I authorize Pediatric Ophthalmology and Adult Strabismus of Fredericksburg to disclose my child's PHI to Designated Adult(s).

My authorization is effective until the patient reaches age 18, or until I revoke my authorization by completing Pediatric Ophthalmology and Adult Strabismus of Fredericksburg "Notice to Revoke" form.

Parent/Legal Guardian/Patient Signature: _____Date: _____

Pediatric Ophthalmology and Adult Strabismus of Fredericksburg

Joseph C. Paviglianiti, M.D.

Phone: 540.681.1211 Fax: 540.681.1544 email: Info@drpavfxbg.com Website: www.drpavfxbg.com

Assignment:

You must provide us with your insurance card. ***If you do not have your card with you, you will be classified as self-paying until you send us a copy of your insurance card.***

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments after payment is received from the patient. Copayment is requested at the time of each visit.

The patient is responsible for fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Authorization to pay benefits to the Physician: I hereby certify services were rendered and direct payment may be made to the physician named hereon. I am financially responsible for charges not covered by my insurance.

"I request that payment of authorized insurance benefits be made either to me or on my behalf of Pediatric Ophthalmology and Adult Strabismus of Fredericksburg for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the healthcare financing administration and it's agents any information needed to determine these benefits payable for related services".

I have read and understand the information on this form.

****Parent/Legal Guardian/Patient Signature: _____Date: _____**

Refraction of your child's eyes at an exam

Your medical insurance usually covers an eye examination based on your visual complaints and medical diagnosis. However, very few medical insurance plans cover a "refraction" to determine whether your vision can be improved with glasses.

A refraction is used as a medical tool to help determine if there is any vision loss and whether or not it is related to a medical condition. **We will bill your insurance $45.00 for this service. However, if it is not covered by your insurance, you will be responsible for payment.**

I have read the above information and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of this service. My co-payment is separate from and not included in the refraction fee.

This notice is good for one year from the date signed.

****Parent/Legal Guardian/Patient Signature: _____Date: _____**