PATIENT REGISTRATION

Joanne Crenshaw, M.D
Shaleen Belani, M.D.

Date: _____

Last Name _____ First Name _____ M.I. ____ Sex: M ___ F ___
Social Security # _____ (Confidential; for billing purposes only) DOB_____ Marital status: S M W D

Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____Work Phone#: _____ Cell phone#:_____
Employer: _____ Occupation: _____ May we call your place of employment? Y N

Email: _____ (Your email gives you access to the patient portal to access/update your medical records.)

Pharmacy Name: _____ City: _____ Phone: _____

Primary Care Provider's Name/Address/Phone: _____
Referring Provider's Name/Address/Phone (if different than PCP): _____

Language: English: ___ Other: ___
Ethnicity: Hispanic ___ Non-Hispanic ___
Race: White ___ Black/African American ___ American Indian/Alaska Native ___
Asian ____ Native Hawaiian/Other Pacific Islander ___ Decline response ___

PRIMARY INSURANCE INFORMATION
Insurance Co. Name: _____ Policy #: _____ Group #:_____
Policy holder's Name: _____ Relationship to Patient: _____
Policy holder's Social Security # _____ DOB_____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____Work Phone#: _____ Cell phone#:_____

SECONDARY INSURANCE INFORMATION
Insurance Co. Name: _____ Policy #: _____ Group #:_____
Policy holder's Name: _____ Relationship to Patient: _____
Policy holder's Social Security # _____ DOB_____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____Work Phone#: _____ Cell phone#:_____

Person(s) you would like to authorize to receive/discuss medical information: _____
Person to contact in case of an emergency: _____ Relationship/phone#: _____

I hereby authorize Joanne Crenshaw, MD, PC to apply for benefits on my behalf for services rendered and authorize the release of any information acquired in the course of my treatment necessary to process insurance claims. I request payment from the above indicated insurance carrier to be made directly to Joanne Crenshaw, MD, PC, realizing that I am responsible for all non-covered charges. I also realize I am responsible for any other costs incurred while collecting my outstanding balance(s). I acknowledge their notice of privacy practices is available to me upon request. I certify that the information I have reported is correct to the best of my knowledge. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian Signature: _____ Date: _____

Our Financial Policy

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy.

I understand that:

Joanne Crenshaw M.D., P.C. does not participate with any vision plans.

It is my responsibility to contact and secure from my insurance plan any referrals, pre-certifications or authorizations prior to receiving medical services. If a referral is required and I do not bring it with me, I will be asked to pay for the visit prior to the exam.

All co-pays, coinsurance and deductible charges as well as past due balances, will need to be paid prior to services rendered. If I have financial difficulty and cannot pay a past due balance, I agree to make payment arrangements by credit card, which will be kept on file and charged at intervals agreed upon by the billing department and myself.

Joanne Crenshaw M.D. PC will file for insurance benefits and accept payments per contractual agreements with participating insurance companies. Knowing the terms, limitations and guidelines of my health insurance policy is my responsibility as a patient and I assume all financial responsibility for any charges incurred as a result of policy termination or coordination of benefits or limitation otherwise not mentioned that results in nonpayment.

Should any balances arise due to insurance copayments, coinsurance, deductibles, insurance denials, termination of coverage, or any other reason, I agree to pay all charges within 60 days of service rendered. Interest of one and a half percent (1.5%) per month, 18% per annum may be charged on all delinquent accounts over 60 days.

There will be a charge for medical records or any forms which need to be filled out by the physician.

There will be a **$75.00** fee for missed appointments not canceled 24 hours prior to the scheduled appointment and a **$250.00** fee for any procedures not canceled three days prior to the scheduled procedure. Legitimate emergencies will be taken into consideration.

If for any reason a check is returned on my account, I will be responsible for a **$35.00** returned check fee in addition to the original fees for services.

IMPORTANT PAYMENT INFORMATION ABOUT REFRACTIONS: A refraction is the process of determining the eye's refractive error. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

However, it is considered a **non-covered** service by Medicare and most insurance companies; thus, it becomes the responsibility of the patient to pay for the refraction portion of the exam. Our fee for the refraction is **$65.00** and is collected at the time of your visit, in addition to any co-payments or deductible due for the medical portion of your exam. If your insurance company pays for the refraction, you will be refunded.

☐ YES I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.
☐ NO I do not want a refraction even if it is needed. I understand that I will not receive a prescription for my glasses or contact lenses.

I have read and understand the above financial policy.

_____	_____	_____
Signature of patient/guardian/parent	**Printed name of patient**	**Date**

Joanne Crenshaw, M.D., P.C.
21135 Whitfield Place, #102
Sterling, VA 20165
(703) 766-6165

NOTICE OF PRIVACY PRACTICES

I, _____, hereby authorize Joanne Crenshaw, M.D., P.C. to use and or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Crenshaw can refuse to treat me.

I have been informed that Dr. Crenshaw has prepared a notice ("Notice") that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such ("Notice") prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Crenshaw in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Crenshaw took before receiving my revocation.

I understand that Dr. Crenshaw has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Crenshaw restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment or health care operations. I understand that Dr. Crenshaw does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Crenshaw must adhere to such restrictions.

_____ _____
Signature of patient or patient's representative Date

_____
Printed name of patient or patient's representative

_____
Relationship to patient

I refuse to sign this consent form, which acknowledges Dr. Crenshaw's implementation of HIPPA privacy regulations.

_____ _____
Signature of patient or patient's representative Date

MEDICAL HISTORY FORM

Name: _____ **Date:_____**

Current eye problem: _____
_____

REVIEW OF **CURRENT** HEALTH:	YES	NO	DETAILS
GENERAL (fever, weight loss, malaise…)	___	___	_____
EAR/NOSE/THROAT (stuffy nose, ear ache, cough, dry mouth…)	___	___	_____
CARDIOVASCULAR (chest pain, racing pulse…)	___	___	_____
RESPIRATORY (congestion, wheezing…)	___	___	_____
GASTROINTESTINAL (stomach upset, diarrhea, constipation)	___	___	_____
GENITOURINARY (urinary flow problems)	___	___	_____
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling)	___	___	_____
SKIN (rashes, suspicious growths)	___	___	_____
NEUROLOGICAL (headache, numbness, paresthesias)	___	___	_____
PSYCHIATRIC (depression, anxiety)	___	___	_____
ENDOCRINE (hot/cold intolerance)	___	___	_____
HEMATOLOGIC (bleeding disorder, anemia)	___	___	_____
ALLERIC/IMMUNOLOGIC (sneezing, swollen nodes, hives)	___	___	_____

*****Please provide the following information if NOT registered on line through our portal:**

Medications you currently take:

_____
_____
_____

Allergies to medications:

___ NONE; IF YES, please list: _____

List all major illnesses: _____
_____

List any surgeries you have had:_____

Family History	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Glaucoma	___	___	___	___	___	___	___	___
Macular degeneration	___	___	___	___	___	___	___	___
Retinal detachment	___	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___
Thyroid disease	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___
Other	___	___	___	___	___	___	___	___

Social History

Smoking: ___ never smoker
___ current smoker (___ packs per day)
___ former smoker (___ pack years)

Alcohol: ___ Yes ___ No; If yes, how much per week? _____

Drug use: ___ Yes ___ No