

**WELCOME TO DR. DANIEL WHANG'S OFFICE
PATIENT INFORMATION**

(Please print)

Patient Name _____ Birthdate _____ Age _____ Sex M F

Parent/Guardian or Responsible Party _____ Relationship _____

Home phone # _____ Work # _____ Patient S. S. # _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

VISION INSURANCE N Y Name _____ Policy # _____

Name of Insured _____ S. S. # _____ Date of Birth of Ins. _____

MEDICAL INSURANCE Y N PRIMARY Ins. Name _____ Policy # _____

Name of Insured _____ S. S. # _____

SECONDARY Ins. Name _____ Policy # _____

Name of Insured _____ S.S.# _____

Previous Eye Doctor _____ Date of Last Exam _____

Whom May We Thank For Referring You _____

Reasons For Exam:

- Routine Checkup New Frames/New Lenses Learning Disability Interest in LASIK
 Contact Lens Evaluation Referred from School or Work Blurred Vision Other _____
 Please list any special Vision needs you may have: (i.e. Computers, Cards, Shooting, Sports, etc.) _____

Have You Previously Worn Glasses? Y N If Yes, for Distance Reading Bifocals Prism

Have You Previously Worn Contacts? Y N If Yes, Soft Hard Gas Permeable

Individual & Family Health History

- | | | | | | | | |
|--------------------------------------|---|--------------------------|------------------------------------|--------------------------|--|--------------------------|------------------------------------|
| Self | Family | Self | Family | Self | Family | Self | Family |
| <input type="checkbox"/> | <input type="checkbox"/> Eye Disease or Surgery | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> | <input type="checkbox"/> Cataracts | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> Blindness | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> | <input type="checkbox"/> ARMD | <input type="checkbox"/> | <input type="checkbox"/> Lung Disease | | |
| <input type="checkbox"/> | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> | <input type="checkbox"/> Thyroid | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol | | |
| <input type="checkbox"/> Other _____ | | | | | | | |

Do You Use Cigarettes or Tobacco? _____ Alcohol? _____ Other Substances? _____

List any MEDICATIONS you are taking (prescription and non-prescription) _____

List any MEDICATIONS to which you are ALLERGIC _____

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 _____

Daniel T. Whang, O.D., LLC

1914 Opitz Blvd. Woodbridge, VA 22191
703.494.7400

OFFICE POLICIES

Our practice strives to provide the highest quality eyecare and eyewear for a fair and reasonable fee. Your understanding of the office policies is essential to better prepare you for your visit.

CO-PAYMENTS/CO-INSURANCES/DEDUCTIBLES

As required by your insurance plan, all co-payments, co-insurances and deductibles are due at the time of service. These fees cannot be waived by our office, as it is an insurance requirement. Payments can be made by cash, Visa, Mastercard, Discover, and American Express. Personal checks are no longer accepted.

INSURANCE/INSURANCE CARDS

When making an appointment, it is your responsibility to inform our office of both your medical and vision insurances. We will make every effort to verify insurances over the phone while making the appointment or before your appointment time, and will not verify insurances at the time of your appointment. You may be asked to present insurance cards (vision and medical) at each visit.

MEDICARE PATIENTS

We are participating providers with Medicare Part B. Medicare patients will be responsible for a refraction (checking eyeglass prescription) fee of \$50, unless you have a separate vision insurance.

SELF-PAY PATIENTS – (NO INSURANCE COVERAGE)

If you do not have valid vision insurance coverage or we cannot verify your benefits before your appointment, full payment is expected at the time of service. If you are unable to pay for your consultation, you may be asked to reschedule your appointment and a \$50 fee will be charged for the missed appointment. Payment for services and materials is required at the time of visit.

MISSED/NOT SHOWING/LATE (FOR YOUR SCHEDULED APPOINTMENT)

We make every effort to prepare for your visit by verifying your insurance and preparing any necessary paperwork prior to your appointment. We strive to respect your time by staying on schedule. We ask that you give a 24 business hour notice when canceling or re-scheduling an appointment. "No showing" for an appointment will result in a \$50 fee. Multiple missed appointments may result in being dismissed from the practice. Please make every effort to notify the office if you will be arriving late to your appointment. If you are late for your appointment, we may need to reschedule your appointment or ask that you wait until the next open appointment spot on the schedule, while we continue seeing the patients who have arrived on time. If we are not able to see you, a fee of \$50 must be paid prior to rescheduling your appointment.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE OFFICE POLICIES AS THEY APPLY TO ME.

Patient Name (Print)

Patient or Guardian Signature

Date

Daniel T. Whang, O.D., LLC

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UNCOOPERATIVE PATIENTS

Our doctor and staff are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment plan and/or presents difficulties in the doctor-patient relationship. Our goal is to accommodate all of our patients' needs. Patients may be dismissed from our practice for inappropriate behavior or language, as they do not help us achieve this goal.

PROGRESSIVE EYEGLASSES (NO LINE BIFOCALS)

Progressive addition lenses generally take about 2 weeks to adapt to. If you cannot adapt to progressive lenses after 2 weeks, we will try make new lenses in another design, at no charge, as long as it is within 30 days of dispensing. Because the original lenses were custom-made, we cannot refund any difference in cost.

FRAME WARRANTY

Our frames carry a minimum one-year limited warranty from the manufacturer. In general, the warranty will cover manufacturer defects. Damage due to lack of proper care to the frame (stepping on a frame, bending the frame, theft, loss, etc.) is not covered.

LENS WARRANTY

Lens manufacturer warranties vary, typically one year, starting from the date the order was placed. Anti-reflective (AR) and Scratch-Resistant (SR) treatments have a 1-year warranty that can be used ONCE during that year, with the following handling fees:

Single vision lenses: \$25

Multifocal lenses: \$50

If lenses were made by an outside office, we will check the prescription in the new eyeglasses to verify accuracy. Only prescriptions that are filled by our office will be re-refracted within 60 days of order date. If you request the doctor to re-refract due to difficulties with lenses made by an outside office, a \$50 refraction fee will be charged.

CONTACT LENSES

Unopened boxes of contact may be exchanged within 30 days of purchase, only if ordered through our office. Boxes that are open, damaged, marked, dented or in obviously unsellable condition cannot be exchanged.

CANCELLATION OF ORDERS

Please note that all orders for glasses will be processed upon receipt of payment. As the fabrication process of glasses is customized, cancellations cannot be accepted once an order has been processed. **ALL SALES ARE FINAL.**

We remain committed to providing you the highest quality products and services.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE OFFICE POLICIES AS THEY APPLY TO ME.

Patient Name (Print)

Patient or Guardian Signature

Date

Notice of Privacy Practices

Daniel T. Whang, O.D., LLC
1914 Opitz Blvd.
Woodbridge, VA 22191
(O) 703-494-7400
(F) 703-491-4220

Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. Daniel T. Whang's Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Relation to Patient if other than self: _____

Date: _____

Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

Daniel T. Whang, O.D., LLC
1914 Opitz Blvd.
Woodbridge, VA 22191
O 703-494-7400
F 703-491-4220

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.

- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 15 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax number shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax number shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site (if applicable).

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax number shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.