



Wayne R. DeVantier, MD
 Roger W. Newsom, MD
 Mark A. Pavilack, MD
 Mark J. Iacobucci, MD

Tom Edmonds, MD
 Leonard A. Rappaport, MD
 Barry F. Atlas, MD
 Kori Elkins, MD
 M. Alison Mercer, OD

(757) 483-0400

Patient Information

PLEASE PRINT

Patient _____

Patient SS# _____
 (For insurance purposes only)

Age ____ DOB ____/____/____

Address _____

 City State Zip

Sex: M F

Single Married Separated Divorced

Name you prefer to be called _____

Home() _____ - _____ Work () _____ - _____
 Cell () _____ - _____
 Email _____

Best time and place to reach you?

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

IN CASE OF EMERGENCY, CONTACT (*Specify someone who does not live in your household.*)

Name _____
 Relationship _____
 Hm# _____ Wk# _____

How did you hear about Tidewater Eye Centers?

- Family Member
- Referral from another patient
Name _____
- Referral from another Doctor
Name _____
- Insurance Co.
- Internet
- Radio TV Newspaper
- Yellow Pages
- Nursing home/Hospital
- Tidewater Eye Center Employee

INSURANCE

PRIMARY

Insurance Co. _____

Subscriber Name _____

Group # _____

Relationship to Patient _____

DOB ____/____/____ SS# _____ - _____ - _____

Is patient covered by additional insurance? Yes No

Insurance Co. _____

ID # _____

SECONDARY

Insurance Co. _____

Subscriber Name _____

ID # _____

Relationship to Patient _____

DOB ____/____/____ SS# _____ - _____ - _____

Is patient covered by additional insurance? Yes No

Insurance Co. _____

Group # _____

Responsible Party:

Name: _____

Relationship: _____

Address: _____ Home # _____

Employer: _____ Work# _____

Responsible Party Signature:

PLEASE BE SURE TO SHOW YOUR INSURANCE CARDS TO THE RECEPTIONIST. NOTIFY US OF ANY CHANGES IN YOUR HOME ADDRESS, PHONE NUMBER, OR INSURANCE COVERAGE.

Assignment of Benefits and Financial Policy Agreement

1. As long as you provide us with your insurance documentation on the date of your visit, Tidewater Eye Centers PC will file the insurance claim with the primary, secondary and tertiary insurance carriers as a courtesy to you. However, an insurance policy is a contract between the patient and their insurance company. **You acknowledge that you will be responsible for all charges not paid by the insurance company, except as otherwise specified by law.**
2. It is the patient's responsibility to provide referrals from primary care physicians and other necessary documents, if applicable, no later than the day on which we provide care.
3. All payments are due at the time of service for medical services or date of order for optical services. Such payments include but are not limited to co-pays, deductibles, charges related to insurance plans with which we do not participate and charges for self-pay balances.
4. Accounts with outstanding balances will be turned over to a collection agency if not paid in full by **90 days** following the date of service (for self-pay patients) or the last insurance payment. However, exceptions (that reduce or extend this 90 day period) may be made when reasonable in our judgment on a case-by-case basis or when dictated by requirements set forth by the insurance carrier. Before turning any account over to collections, we will attempt to contact the patient or their responsible party. **PLEASE NOTE: If the account balance is forwarded to a collection agency, the patient will be released from the care of Tidewater Eye Centers.**
5. Monies due on unclaimed optical orders will be turned over to collections as early as 30 days after orders are placed. If optical orders are modified after orders are placed with optical labs, patients may owe a balance on the original order if our optical lab has already cut lenses, etc.
6. If your account is referred to an attorney or other collections agency, you agree to pay all collections costs including attorney fees of thirty-three and one-third percent (**33 1/3%**) of the principal amount turned over for collections.
7. You hereby assign to Tidewater Eye Centers PC for its services to you any benefits available for such services under insurance policies, workers compensation, governmental agency, disability, or other programs. Similarly, you hereby assign to Tidewater Eye Centers PC any proceeds from settlements, judgments or verdicts in your favor from third party liability claims for your injuries treated by Tidewater Eye Centers PC. With respect to such third party liability proceeds, Tidewater Eye Centers PC will be deemed to have a claim in an amount equal to its normal charges for services rendered, together with attorney fees, costs, and interest, as applicable. Tidewater Eye Centers PC will be deemed to have a lien against the proceeds in such amount. You agree that Tidewater Eye Centers, PC will be authorized to receive direct payment of all assigned benefits/ proceeds, and that any attorney, insurance carrier or agency handling or disbursing such benefits or proceeds is hereby authorized and directed to withhold and promptly pay over to Tidewater Eye Centers, PC the lesser of the full amount of its charge or the total proceeds or benefits available, without offset.
8. To the extent necessary to determine liability for payment and to obtain reimbursement, you agree that Tidewater Eye Centers, PC may disclose your record to any appropriate party related to the Social Security Administration, insurance or benefit payer.
9. **X**_____By initialing on this line, I agree to pay **\$30.00** for my refraction charge at the time this service is rendered and/or the prescription is dispensed. The refraction is a separately billable service that consists of the technician or doctor placing different lenses in front of your eyes to give the best vision for glasses and/or contact lenses. The refraction is deemed a non-covered service by most insurances, including Medicare, Medicaid, and supplemental plans. If your insurance does cover this test, then you will be refunded once they have provided payment. There are a select few insurances for which we will not collect this fee at the time services are rendered; however, this does not release you from payment if the insurance guidelines change. Further details of the need for this test can be provided by your technician or doctor.

By signing below, you represent that you have read and fully understand this agreement, and that Tidewater Eye Centers, PC has made no representations not stated on this financial policy.

Photocopies of this agreement will be deemed to be duplicative originals for all purposes.

Signature: **X**_____ Date: _____

Tidewater Eye Centers, P.C.
Medical History Questionnaire

NAME _____ DATE _____

Date of Birth _____ Age _____ Family Dr. _____ Doctors Phone# _____

What pharmacy do you use? _____ Pharmacy Phone# _____

YOUR PAST MEDICAL HISTORY

Please list all medications you are currently taking, including over the counter and any eye medications. Please include name and dosage. _____

Are you ALLERGIC to any medication(s)? **YES NO Please circle one**

If YES, please list and explain reaction: _____

PLEASE CIRCLE IF YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS:

Diabetes / High Blood Pressure / Heart Disease / Thyroid Disease / AIDS / HIV+ / Stroke / Cancer / Lupus / Arthritis / Rheumatoid Arthritis / Hepatitis / Syphilis / Head Trauma or Injuries / Asthma / Emphysema / High Cholesterol

Please list any other illnesses not mentioned above:

List any surgical procedures (other than eye surgery) you have had:

Do you have a Pacemaker or Automated Internal Cardiac Defibrillator (AICD)? **YES NO Please circle one**

REVIEW OF SYSTEMS (ORGAN SYSTEM)

Do you currently have any problems in the following areas? PLEASE CHECK YES OR NO TO EVERY QUESTION. IF YES, PLEASE PROVIDE EXPLANATION.

	YES	NO	EXPLAIN
General/Constitutional (Fever, Weight Loss, Etc.)	_____	_____	_____
Ears, Nose, Throat (Sinus, Dry Mouth, Etc.)	_____	_____	_____
Cardiovascular (Chest Pain, Shortness of Breath, Etc.)	_____	_____	_____
Respiratory (Wheezing, Coughing, Etc.)	_____	_____	_____
Gastrointestinal (Upset Stomach, Diarrhea, Etc.)	_____	_____	_____
Muscles, Bones, Joints (Aches & Pains, Arthritis, Etc.)	_____	_____	_____
Skin (Rashes, Irritations, Etc.)	_____	_____	_____
Psychiatric (Depression, Anxiety)	_____	_____	_____
Neurologic (Weakness, Headaches, Etc.)	_____	_____	_____
Allergic/Immunologic (Hives, Itching, Etc.)	_____	_____	_____
Endocrine (Diabetes, Hypothyroid, Etc.)	_____	_____	_____
Blood/Lymph (Cholesterolemia, Anemia, Etc.)	_____	_____	_____

(OVER)

PLEASE CHECK YES OR NO FOR EVERY QUESTION BELOW:

Have you ever been diagnosed with any of the following eye problems?

	YES	NO		YES	NO
Cataracts	_____	_____	Tumor of the Eye	_____	_____
Blurred Vision	_____	_____	Herpes of the Eye	_____	_____
Glaucoma	_____	_____	Retinal Problems	_____	_____
Macular Degeneration	_____	_____	Eye Injury	_____	_____
Crossed Eye	_____	_____	Eye Infections	_____	_____
Lazy Eye	_____	_____	Iritis	_____	_____
Other _____					

Please check any vision problems you may be experiencing **WITH YOUR GLASSES ON:**

<input type="checkbox"/> Reading Newspaper	<input type="checkbox"/> Seeing Road Signs
<input type="checkbox"/> Reading Medicine Bottles/Phone Book	<input type="checkbox"/> Driving at Night Due to Glare
<input type="checkbox"/> Seeing to Sew	<input type="checkbox"/> Seeing Halos Around Lights
<input type="checkbox"/> Watching Television	<input type="checkbox"/> Glare from Sunlight
<input type="checkbox"/> Difficulty with Sports, Hobbies, Etc.	<input type="checkbox"/> Difficulty with Home/Work Related Activities

List any other specific vision problems you may be experiencing: _____

YOUR EYE HISTORY

Date of last eye exam: _____ Do you currently wear contact lenses? **YES** **NO**

If Yes, what kind do you wear? _____ How many years? _____

Do you wear prescription eyeglasses? **YES** **NO** If yes, how old are your current glasses? _____

List any eye surgeries or laser treatments you have had, including the date and surgeon's name:

FAMILY HISTORY

Do you have a family history of glaucoma, macular degeneration or other inherited eye disease? **YES** **NO**

If yes please list disease and family members affected: _____

SOCIAL HISTORY

Current Occupation: _____

Do you drink alcohol? **YES** **NO** If Yes: occasional 1 day 2-3 day 4+ day

Do you smoke? **YES** **NO** If Yes: occasional: 1/2 pack day 1 pack day 1+ pack day

Physician's Signature: _____

TIDEWATER EYE CENTERS PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Tidewater Eye Centers provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ❖ Protected health information may be disclosed or used for treatment, payment or health care operations
- ❖ Tidewater Eye Centers has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- ❖ Tidewater Eye Centers reserves the right to change the Notice of Privacy Policies
- ❖ The patient has the right to restrict the uses of their information but Tidewater Eye Centers does not have to agree to those restrictions
- ❖ The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Family and Friends. It is the office policy of Tidewater Eye Centers, P.C. not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information (including but not limited to appointment times, prescription and payment) to be provided to family members, friends, or caretakers, or if you want us to leave a detailed messages regarding your care please indicate that below. By signing below, you authorize the following people/message systems to receive detailed information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____

Parent: _____

Other: _____

May we leave a detailed message on your home answering machine? YES NO

Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

Signature of Patient OR person with power of attorney: _____

Printed name of party above: _____

Date: _____

Patient DOB: _____

Received By: _____

Printed Name- TEC Representative