TIDEWATER EYE CENTERS
First in the eyes of our patients

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(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
Spouse's Name _____
Ethnicity_____ Race _____
Language _____
Name you prefer to be called_____

Home( ) _____-_____ Work ( ) _____-_____
Cell ( ) _____-_____
Email _____
Best time and place to reach you?
_____

Family Physician:_____

Occupation _____

Employer _____

Employer Address _____

IN CASE OF EMERGENCY, CONTACT
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 _____

ID # _____

Group # _____

Relationship to Patient _____

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

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.

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# _____
Optometrist?_____

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 / Lupus / Arthritis / Rheumatoid Arthritis / Hepatitis / Syphilis / Head Trauma or Injuries / Asthma / Emphysema / High Cholesterol / Cancer, if so, what type:_____

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**:

___ Reading Newspaper
___ Reading Medicine Bottles/Phone Book
___ Seeing to Sew
___ Watching Television
___ Difficulty with Sports, Hobbies, Etc.
___ Seeing Road Signs
___ Driving at Night Due to Glare
___ Seeing Halos Around Lights
___ Glare from Sunlight
___ 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 Diabetes, Coronary artery disease, Cancer, Lupus, Rheumatoid arthritis, Thyroid disease, 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 disclosers 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 agreed to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosers 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 of 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 message 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

PATIENT FINANCIAL POLICY

Thank you for choosing **TIDEWATER EYE CENTERS, P.C.** (the "**Practice**") for your eye care needs. This Patient Financial Policy (this "**Policy**") sets forth the Practice's policies concerning the payment and reimbursement for services rendered by the Practice. This Policy applies to all of the Practice's patients. By signing below, you agree to comply with the terms of this Policy. The original signed Policy will be maintained in your file and a copy may be provided to you upon your request.

Please initial on the line beside each section after reading and sign and date on the final page.

INSURANCE AND PAYMENT: The Practice accepts most major insurances and will file for insurance benefits as a courtesy to its patients. Please note that your insurance provider has a contract with you and that you are ultimately responsible for 100% of all charges for services rendered by the Practice to you to the extent permitted by law. You are responsible for providing the Practice with the correct insurance information at the time of service. You hereby certify that the information provided to the Practice regarding your insurance coverage is current, true, and accurate, to the best of your knowledge. If you fail to provide the Practice with such information, the Practice will hold you 100% financially responsible for all charges incurred to the extent permitted by law. Should your insurance company fail to pay any insurance claim for services rendered by the Practice, then the Practice will hold you financially responsible for 100% of the charges submitted to the insurance carrier to the extent permitted by law. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the services were rendered.

Patients are expected to pay **AT THE TIME OF SERVICE**. This includes payment for co-payments, co-insurance, and/or deductible amounts. Payments may be made by cash, check, and/or credit card (MasterCard, Visa, Discover, American Express). In the event that a check is returned for insufficient funds, a **$75** returned check fee will be charged to your account.

If you have a high deductible insurance plan and if the deductible has not met for the current service year, then you will be required to pay a **$150** deposit at the time of service that will be applied towards charges incurred. Once your insurance has been billed, any further balance will be 100% your responsibility.

Patients who are unable to pay their co-payments, co-insurance, deductibles, and/or non-covered charges at the time of service may be asked to reschedule their visit. Patient accounts that have not been paid by the patient and/or insurance for 90 or more days since the office visit, may be referred to a collection agency or an attorney for collection.

I understand and agree that I am financially responsible for all charges whether or not billed to or paid by said insurance to the extent permitted by law. I agree to assume responsibility for all charges incurred as well as all costs of collection should I default in payment and this matter be referred to a third party collector/attorney, including, but not limited to, court costs and attorneys' fees of 33.33% of the balance placed with the attorney.

Patient Initials: _____

REFRACTION: Refraction is a test that measures your best corrected vision. This test is necessary if you request a new prescription for glasses and/or contact lenses or if you have otherwise had a change in your vision. The refraction test is considered a "non-medical" service by most insurance companies, including Medicare. The charge for the refraction test is **$50.** If a refraction test is a necessary part of your exam, we will perform it and you will be asked to pay the fee at check out, if we dispense the prescription.

Patient Initials: _____

SELF-PAY PATIENTS: Self-pay patients must pay **$125** at registration in advance for their office visit and then must pay any additional charges incurred during the visit at check-out after such visit. The person paying the additional charges at the end of the visit may be given a prompt-pay discount. This discount, though, is only available if payment is made in full on the date of service.

Patient Initials: _____

REFERRALS: Some patients will be required by their insurance company to obtain a referral from their primary care physician authorizing their visit to the Practice. It is the patient's responsibility to obtain this referral in advance of their visit to the Practice and to be sure that the referral is communicated to the Practice before the patient's visit. Should you arrive at the Practice for any visit without the required insurance referral, and still choose to be seen by our providers, you will be expected to pay 100% of all office charges at the time of visit and you will be required to sign a waiver acknowledging your responsibility for such charges. These charges will include the amount of **$150** at registration for the office visit and any additional charges incurred during such visit, which shall be payable at check-out following your visit. If a referral is ultimately received for the visit and if your insurance carrier pays the Practice for such visit, then the Practice will refund you the amount of the insurance payment. Patients presenting without a required referral that do not agree to sign a waiver or are otherwise unable to pay at least the **$150** office visit fee may be asked to reschedule their appointment.

Patient Initials: _____

OPEN BALANCES: Should you receive a bill from the Practice, payment in full of the "Patient Balance" is due by the due date indicated, unless other arrangements have been specifically made in advance with the Practice's Billing Office. Patients with an open balance on previous office visits or surgical procedures will be asked to pay 50% of any open balance at the time of the next visit. Patients who are unable to pay such amount on any open balance may be asked to reschedule their visit. Patients who are having trouble making payments on open balances should contact the Practice's Billing Office at (757) 397-7858 in order to discuss payment arrangements. In these circumstances, the patient may be asked to provide personal financial information, which the Practice will use to determine an appropriate payment arrangement.

Patient Initials: _____

MISSED APPOINTMENTS/SURGERIES: Please help us serve our patients better by keeping your scheduled appointments and arriving to your scheduled appointments on time. In the event you are unable to keep your scheduled appointment, please give the Practice notice at least 1 full business day prior to your scheduled appointment for regular clinic visits and at least 5 days prior to any scheduled surgery. Failure to provide such timely notice of cancellation will result in a missed appointment or late cancellation charge in the following amounts:

- *Clinic Visits*: The missed appointment or late cancellation fee for a clinic visit is **$40**
- *Surgery*: The missed appointment or late cancellation fee for a surgery is **$150**

Patient Initials: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION FOR PAYMENT PURPOSES: By signing below, you authorize the release of any necessary medical or other relevant information for this or any related claim to your insurance company(ies). You permit a copy of this authorization and assignment to be used in place of the original. This will remain in force and effect unless and until revoked by you in writing.

Patient Initials: _____

MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made on my behalf to the Practice for any service furnished to me by the Practice. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services ("**CMS**") and its agents any information needed to determine these benefits payable for related services.

_____

Medicare Number

_____ _____

Beneficiary Signature Date

_____ _____

Witness Signature Date

I HAVE READ AND UNDERSTAND THE PRACTICE'S PATIENT FINANCIAL POLICY SET FORTH ABOVE AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME. BY SIGNING BELOW, I HEREBY CONSENT TO TREATMENT BY THE PRACTICE AND ITS PROVIDERS AND ACCEPT RESPONSIBILITY FOR PAYMENT OF FEES FOR ALL SERVICES RENDERED BY THE PRACTICE TO THE EXTENT PERMITTED BY LAW.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date