# Patient Information: Welcome to our office!

TODAY'S DATE: _____ /_____ /_____

PATIENT'S LEGAL NAME: _____ NICKNAME/PREFERRED FIRST NAME: _____
LAST FIRST MIDDLE

BIRTHDATE: ____ /____ /_____ GENDER: MALE / FEMALE

ADDRESS: _____ APT#: _____

SOCIAL SECURITY #: __ __ __ - __ __ - __ __ __ __

CITY/STATE: _____ ZIP CODE: _____

PREFERRED LANGUAGE: ENGLISH SPANISH _____

HOME PHONE: (_____) _____ PREFERRED METHOD: HOME CELL EMAIL

RACE: WHITE HISPANIC BLACK/AFRICAN AMERICAN ASIAN
AMERICANINDIAN/ALASKANATIVE HAWAIIAN/PACIFICISLANDER
MIDDLEEASTERNER OTHER: _____

WORK PHONE: (_____) _____ DETAILED MESSAGE: YES NO

CELL PHONE: (_____) _____ TEXT: YES NO

EMAIL*: _____ @ _____

STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYMENT: RETIRED DISABLED NOT EMPLOYED EMPLOYED PART-TIME / FULL-TIME @ _____ OCCUPATION: _____

STUDENT PART-TIME / FULL-TIME @ _____ GRADE: _____

HOW DID YOU HEAR ABOUT US? [FORMER PATIENT] [DOCTOR REFERRAL] [PATIENT REFERRAL] [TRIWEST] [PHONEBOOK] [INTERNET] [ER] [WORKMAN'S COMP] _____

*RESPONSIBLE PARTY/Guarantor INFORMATION (MUST COMPLETE if patient is under 18 or is not financially responsible by law):*

LEGAL NAME: _____ BIRTHDATE: ___ /___ /_____ SS#: __ __ __ - __ __ - __ __ __ __
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT: SPOUSE MOTHER FATHER OTHER: _____ HOME/CELL/DAY PHONE: [SAME AS PT ] (_____) _____

ADDRESS: [SAME AS PT ] _____ APT #: _____ CITY: _____ ST: _____ ZIP CODE: _____

ADULT WHO BROUGHT THE PATIENT: _____ DATE OF BIRTH: ____ /___ /_____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT: MOTHER FATHER GRANDPARENT SPOUSE UNCLE AUNT CASE WORKER HOUSEPARENT CAREGIVER _____

ADDRESS: [SAME AS PATIENT] _____ SOCIAL SECURITY #: __ __ __ - __ __ - __ __ __ __ PHONE: (_____) _____

**********

REASON FOR VISIT: [YEARLY EYE HEALTH/VISION EXAM]* [EYE HEALTH PROBLEM]

THIS VISIT IS REFERRED BY: SELF PRIMARYCARE PHYSICIAN HOSPITAL/ER URGENTCARE WORKMAN'S COMP _____

*There is no guarantee your visit today will be routine. If the findings reveal a more pressing eye health issue that may interfere with refractive findings, the doctor will treat your medical issue.

**VISUAL LIFESTYLE:**

HOBBIES? [READING] [KNITTING/SEWING] [MUSIC] [WOODWORKING] [GARDENING] [VIDEO GAMES] [FISHING] [GOLF] OTHER: _____

ARE YOU EXPOSED TO 2 HOURS OR MORE OF THE SUN/UV RAYS PER DAY? [YES, FROM WORK/SPORTS/HOBBIES] [NO, I PREFER TO STAY INDOORS]

HOW LONG ARE YOU ON THE COMPUTER? [NEVER, I DON'T TOUCH THAT STUFF!] [UP TO 1 HR] [UP TO 2 HRS] [UP TO 4 HRS] [UP TO...IT'S MY LIFE!]

DO YOU HAVE NIGHT VISION ISSUES WHEN DRIVING? [YES, HEADLIGHTS ARE BLINDING!] [NO, WHAT DO YOU MEAN? I'M A GREAT DRIVER]

WOULD YOU LIKE TO LEARN ABOUT ENHANCING YOUR LIFE THROUGH SHARPER VISION? [MOST DEFINITELY...YES!] [NO, MY LIFE IS FINE.]

WHEW! ONE DOWN, 3 MORE TO GO!... PLEASE COMPLETE THE NEXT PAGE.

# Patient Financial/Consent Information

To provide the best medical care, our relationship is with you, not your insurance company. Not all services we provide are a covered benefit of all insurance policies. For this reason, all charges remain the responsibility of the patient, regardless of the amount of benefit might receive from your carrier. If you need to discuss your account or have financial concerns, please refer to the check out associate or front desk.
In order to file with your insurances, we must have accurate patient demographic information along with a photo identification and copy of your current insurance card(s).

**Today's Choice of Payment:** (circle all apply) Self Pay Medical Insurance(s) Vision Plan Workman's Compensation

## Medical Insurance(s):

**Primary Medical:** None BlueCrossBlueShield(BCBS) Humana Medicare UHC BlueCare TennCare*Select* _____

**Main Name on Card:** [self] spouse/parent/other _____ **SS #:** ___ ___ ___-___ ___-___ ___ ___ ___ **BirthDate:** ___ /___ /_____

**Second Medical:** None BCBS Cigna Humana Medicaid Medicare TriCare UHC BlueCare TennCare*Select* _____

**Main Name on Card:** [self] spouse/parent/other _____ **SS #:** ___ ___ ___-___ ___-___ ___ ___ ___ **BirthDate:** ___ /___ /_____

**Third Medical:** None BCBS Cigna Humana Medicaid Medicare TriCare UHC BlueCare TennCare*Select* _____

**Main Name on Card:** [self] spouse/parent/other _____ **SS #:** ___ ___ ___-___ ___-___ ___ ___ ___ **BirthDate:** ___ /___ /_____

## Vision Plan: (Please be aware that we are out of network with most vision plans)

**Vision Plan*:** None NAA VisionCareDirect DirectReimbursement Other: _____

**Main Name on Card:** [self] spouse/parent/other _____ **SS #:** ___ ___ ___-___ ___-___ ___ ___ ___ **BirthDate:** ___ /___ /_____

*Vision plan covers ONLY healthy eye exams. If any medical issue is detected, medical insurance will be filed and you may be responsible for a refraction fee which medical insurance considers as a non-covered service.

## Workman's Compensation (WC):

We will bill your employer or the worker's compensation carrier only if we have correct patient demographic information along with a photo identification and all information below. It will be your responsibility to provide us with the correct name and address of your employer or the insurance company along with the claim number that covers your visit(s). All charges remain the responsibility of the patient regardless of coverage by your carrier.

**Employer's Name:** _____ **Work Number:** _____

**Person to Contact:** _____ **Phone Number:** _____

**Name of WC Insurance:** _____ **Fax Number:** _____

**Address:** _____ **Claim Number:** _____

**City, State, Zip** _____, _____ _____

## Consent for Release of Confidential Information: Please tell us to whom we may share your information

**All records are protected under federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without the patient's written consent unless otherwise provided for in the regulations. This consent may be revoked at any time except for the extent that action has been taken in reliance on it, and that in any event this consent will automatically expire one year from today.**

_____ **Please DO NOT disclose any health and financial information to any individual but myself.**

_____ **MAY disclose my health and financial information to the specific individual(s) indicated below. Please print the name(s) of the persons/entities/doctors**

| (name) | (date of birth) | (relationship) | (phone number) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***By signing below, I am stating all information I provide today on all forms is accurate to the best of my knowledge.***

**SIGNATURE:** X _____

# Patient Health Information (p1)

TODAY'S DATE: _____ /_____ /_____

LEGAL NAME: _____ (LAST / FIRST / MIDDLE) BIRTHDATE: ___ /___ /_____ GENDER: M / F

## CURRENT EYE HEALTH ISSUE (ROV): *PLEASE CIRCLE ALL THAT APPLY. [NO ISSUES, JUST NEED VISION EXAM]*

| | | | |
|---|---|---|---|
| BLURRED VISION @ NEAR | BLURRED VISION @ FAR | BURNING SENSATION | DISTORTED VISION/HALOS |
| DOUBLE VISION | DRYNESS | EYE PAIN OR SORENESS | FLASHES/FLOATERS IN VISION |
| FOREIGN BODY SENSATION | GLARE/LIGHT SENSITIVITY | INFECTION OF EYE/LID | ITCHING |
| LOSS OF SIDE VISION | LOSS OF VISION/BLINDNESS | MUCOUS DISCHARGE | REDNESS |
| SANDY/GRITTY FEELING | STYE/CHALAZION | TEARING/WATERING | TIRED EYES |

OTHER: _____

## EYE HEALTH HISTORY: *PLEASE CIRCLE ALL THAT APPLY.*

[NOT APPLICABLE]

| | | |
|---|---|---|
| CATARACTS | COLORBLIND | DROOPING EYELID(S) |
| EYE INFECTIONS | GLAUCOMA | LAZY/CROSSED EYES |
| LASIK/PRK | MACULAR DISEASE | PROTRUDING EYES |
| RETINAL DETACHMENT | RETINAL DISEASE | |

EYE INJURY: _____

OTHER: _____

LAST EYE EXAM? LAST YR / 2 YRS AGO / BEEN AWHILE / NEVER HAD ONE O' EM

INTERESTED IN LASIK? YOU BETCHA! / NO TOUCHY! / WHAT IS THAT? EDUCATE ME!

DO YOU WEAR: EYEGLASSES? Y / N / DON'T NEED 'EM THANGS!

AGE OF EYEGLASSES? 1 YR / 2 YRS / MAYBE 3-5 YRS / GOSH! FOR...EVER!

WEAR CHEATER READERS? Y / MAYBE / I'M NOT OLD ENOUGH

WEAR BIFOCALS? NO, STILL NOT OLD ENOUGH! / LINED / NOLINE/PROGRESSIVE

UPDATE CURRENT FRAME? YES / MAYBE / NO, JUST GOT IT LAST YR / NO, IT STILL HAS 9 OR SO MORE LIVES

WEAR CONTACT LENSES? Y / NO TOUCHY / NO BUT INTERESTED

IF YES, BRAND OF CL: _____

SOLUTION: _____

AGE OF CURRENT CONTACTS?

NOT WEARING ANY...RAN OUT OF SUPPLY — LESS THAN 1 WEEK

LESS THAN 1 MONTH — UMM, THEY DON'T FEEL TOO ICKY

## VITAL INFORMATION:

HEIGHT: ___ FT, ___ IN WEIGHT: ___ LBS

PRIMARY CARE PHYSICIAN (PCP): _____

PCP OFFICE PHONE: (_____) _____

PHARMACY YOU USE:

| | | | |
|---|---|---|---|
| CVS | FOOD CITY | KROGER | LEE'S |
| WALGREENS | WALMART | REAMS | RIGHTSOURCE |
| STEWARTS | OTHER: _____ | | |

LOCATION OF PHARMACY: _____

PHONE: (_____) _____

## SOCIAL HISTORY:

DO YOU DRINK ALCOHOL? *Yes / No*

*IF YES: AMOUNT/DAY:* *SOCIAL* *LESS THAN 4* *4 to 6* *JUST NEVER ENOUGH*

ARE YOU CURRENTLY USING TOBACCO PRODUCTS? *Y / N*

*IF YES: _____PACK/DAY*

HAVE YOU EVER USED TOBACCO? *Y / N*

DO YOU USE ILLEGAL DRUGS? *Y / N*

## ALLERGIC to MEDICATIONS? *Y / N*

If yes, please list:

_____ _____ _____

## LIST ALL MAJOR INJURIES, SURGERIES, HOSPITALIZATIONS YOU HAVE HAD:

[NOT APPLICABLE]

## LIST ALL CURRENT MEDICATIONS YOU ARE TAKING:

(include over the counter, home remedies, eyedrops, etc.)

[NOT TAKING ANY] [I HAVE A LIST]

| MEDICATION | TREATING CONDITION: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

DON'T FORGET! THERE IS ONE MORE PAGE. PLEASE FINISH ME!

# Patient Health Information (p2)

TODAY'S DATE: _____ /_____ /_____

LEGAL NAME: _____ BIRTHDATE: ___ /___ /_____ GENDER: M / F
LAST FIRST MIDDLE

**REVIEW of SYSTEMS:** *CIRCLE ALL PROBLEMS YOU **HAVE or HAD**:* [NOT APPLICABLE CUZ I AM HEALTHY ...AND NOT PREGNANT!]

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CONST: | Developmental Disabilities | CARDIO: | Hypertention/High Blood Pressure | GENITOURIN: | Kidney Disease | ENDO: | Type 2 Diabetes Mellitus |
| | Cancer | | Stroke/CVA | | Prostate Disease/Cancer | | Type 1 Diabetes Mellitus |
| | Fatigue Syndrome | | Heart Disease | | STD/Herpetic/Chlamydia | | Thyroid Dysfunction |
| ENT: | Hearing Loss | | Vascular Disease | | Benign Prostate Hypertrophy | | Hormonal Dysfunction |
| | Sinusitis | | Congestive Heart Failure | | Pregnant | LYMPH/HEM: | Anemia |
| | Dry Mouth | RESPIR: | Cigarette Smoker | | Nursing | | Large Volume Blood Loss |
| | Laryngitis | | Asthma | | Gonorrhea | | Ulcer |
| NEURO: | Multiple Sclerosis | | Bronchitis | | Syphilis | | Hypercholesteremia |
| | Epilepsy | | Emphysema | MUSC/SKEL: | Arthritis | | HIV positive |
| | Cerebral Palsy | | Chronic Obstruction | | Osteoarthritis | | Hepatitis |
| | Tumor | | Sleep Apnea | | Fibromyalgia | ALLERGY/IMM: | Drug Allergies |
| | Stroke/CVA | GASTROINT: | Crohn's | | Muscular Dystrophy | | Enviromental Allergies |
| | Migraine/Headache | | Colitis | | Ankylosing Spondylitis | | Rheumatoid Arthritis |
| | Autism Spectrum Disorder | | Ulcer | | Osteoporosis | | Lupus |
| | Alzheimer's/Dementia | | Acid Reflux | | Gout | | Sjorgen's Syndrome |
| PSYCH: | Depression | | Celiac Disease | INTEG: | Eczema | OTHER: | _____ |
| | Attention Deficit | | | | rosacea | | _____ |
| | Anxiety Disorder | | | | Psoriasis | | _____ |
| | Bipolar Disorder | | | | Herpes Simplex/Cold Sores | | |
| | | | | | Herpes Zoster/Shingles | | |

**********

**FAMILY HISTORY:** *PLEASE CHECK BELOW ALL KNOWN IN YOUR FAMILY:*

| DISEASE/CONDITION | FATHER | MOTHER | BROTHER | SISTER | SON | DAUGHTER |
|---|---|---|---|---|---|---|
| ARTHRITIS | ___ | ___ | ___ | ___ | ___ | ___ |
| CANCER | ___ | ___ | ___ | ___ | ___ | ___ |
| DIABETES | ___ | ___ | ___ | ___ | ___ | ___ |
| HEART DISEASE | ___ | ___ | ___ | ___ | ___ | ___ |
| HIGH BLOOD PRESSURE | ___ | ___ | ___ | ___ | ___ | ___ |
| KIDNEY DISEASE | ___ | ___ | ___ | ___ | ___ | ___ |
| LUPUS | ___ | ___ | ___ | ___ | ___ | ___ |
| THYROID DISEASE | ___ | ___ | ___ | ___ | ___ | ___ |
| | | | | | | |
| BLINDNESS/AMBLYOPIA | ___ | ___ | ___ | ___ | ___ | ___ |
| CATARACT | ___ | ___ | ___ | ___ | ___ | ___ |
| CROSSED EYES/STRABISMUS | ___ | ___ | ___ | ___ | ___ | ___ |
| GLAUCOMA | ___ | ___ | ___ | ___ | ___ | ___ |
| MACULAR DISEASE | ___ | ___ | ___ | ___ | ___ | ___ |
| MACULAR DEGENERATION | ___ | ___ | ___ | ___ | ___ | ___ |
| RETINAL DETACHMENT | ___ | ___ | ___ | ___ | ___ | ___ |
| RETINAL DISEASE | ___ | ___ | ___ | ___ | ___ | ___ |
| OTHER: _____ | ___ | ___ | ___ | ___ | ___ | ___ |

**********

# MIDDLE CREEK EYE CENTER FINANCIAL AND OFFICE POLICY

Dedicated to providing the most efficient and reasonable eye health and vision care services to you and your family, our office feels that your understanding of the financial and disclosure policy is also an essential component of the care. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

NOT ALL SERVICES WE PROVIDE ARE A COVERED BENEFIT OF ALL INSURANCE POLICIES; therefore, all charges remain the responsibility of the patient regardless of benefit amount might receive from the carrier(s). All comprehensive exams at Middle Creek Eye Center, Inc. which includes Diabetic Eye Exams consist of a full eye health evaluation, which includes assessment for glaucoma and cataracts and a refraction to evaluate the visual system. Refraction Service is usually considered a **"non-covered"** service with most medical insurances. A Contact Lens Evaluation is an optional **"non-covered by medical insurance"** service which is an **additional** charge and may be performed on the same day or within thirty (30) days of the routine eye exam.

Methods of acceptable payments are ***Cash, LOCAL Bank Check*, CareCredit*** or ***Visa/MasterCard/Discover.*** **When paying by check, the account holder expressly authorizes Middle Creek Eye Center, Inc. to electronically debit your bank account for the amount of the check. If the check is dishonored or returned for any reason, an additional processing fee of **$30** (or legal limit) plus any applicable legal fees will be charged. The use of a check for payment is the acknowledgement and acceptance of this policy and its terms.*

**Self-Pay Policy**

•Self paying patient are required to pay an estimated amount for the exam before services are rendered. Any remaining balance on your account will be collected at check out.

**Medical Insurance and Vision Plan Policy*:**

- For insured patient**, it is our policy to file for insurance as a courtesy to you. We must have accurate and complete insurance information at the time of service.
- If provided service is not covered by your insurance policy, you will be responsible for balance due at the time of service.
- If payment or explanation of your benefits from your insurance company is not received within sixty (60) days, you will be responsible for the full balance due. In these special cases, you are responsible in contacting your insurance company for the payment of your services.
- Estimated deductible/coinsurance or copayment of participating insurance plans will be collected at the time of service. The insurance policy will determine the final financial distribution.
- Due to insurance company regulations, vision plans and medical insurances may **NOT** be filed on the same day of service.

*Our office will ONLY file to participating insurances. It is ***the patient's responsibility*** to provide our office with accurate billing information and to understand the insurance benefits and financial coverages. If the insurance plan requires a ***referral***, the patient is responsible to obtain the referral before the exam. If our office is not able to verify your insurance coverage on the date of service, you will be required to pay in full. Our office will still try to file with your insurance and any refund will be issued if applicable. **Non-Local patients are required to pay in full even if insurance is presented and an itemized receipt will be provided to the patient to file with his/her insurance. Upon request, our office may try to file with your insurance and any refund will be issued if applicable.

**Workman's Compensation Policy**

- It is our policy to bill your employer or workman's compensation carrier for services rendered. However, it is your responsibility to provide all information necessary for filing.
- If payment is denied from your worker's compensation carrier or inaccurate/incomplete information is given, you will become responsible for the entire balance of your services.

**Divorce/Custody Case/Personal Representative Policy:** The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, who has custody, or who has the insurance. For situations where the patient is not able to sign legal documents, the personal representative, such as Power of Attorney, must provide notarized copies of necessary legal documents, must be available to sign all documents, and must be present during the exam.

**After Hours Charge:** There will be a charge of $85 for any visits that take place after normal business hours.

**Overdue Balances Policy:** All over-due balances over 30 days old will be charged a late fee at a rate of five dollars ($5) per month. Balances over three(3) months old will be handled by Transworld Billing Department. All over-due balances over ninety (90) days will be sent to Transworld Collections Department. All accounts sent to collections will be charged $50.00 collection fee in addition to the account balance.

**Material Purchase and Refund Policy:** If materials are to be ordered, **at least 50% payment** will be required at the time of the order. The remaining balance will be due when you receive your materials. There is a **30% cancellation fee*** on non-dispensed frames within ***60 days*** of purchase/order date. All spectacle lenses are custom made and therefore are **nonrefundable**. All dispensed frames are **nonreturnable and nonrefundable**. Any unopened, unmarked, undamaged and non-expired boxes of soft contact lenses purchased from our office may be returned and refunded minus a **30% processing fee***. There is a **30% cancellation fee*** on RGPs (rigid contacts) and soft contact lens orders within ***30 days*** of purchase/order date. **NO REFUND** on RGPs after ***30 days*** from purchase/order date. **NO REFUND** on budget packages, any professional services, and insurance-filed purchases. Our office reserves the right to cancel any orders not picked up after 60 days from purchase/order date and NO REFUND/CREDIT will be issued. **Cancellation and processing fees are calculated from the original cost before any discounts.*

**By signing below:** *I have read and understood the financial policies of Middle Creek Eye Center, Inc., and also I understand that Middle Creek Eye Center, Inc. reserves the right to change any and all fees at any time without notice. I request that payment of authorized Medicare, BC/BS of TN, and all other insurance companies' benefits be made on my behalf to my attending physician for medical services furnished me. I authorize the release of any medical information about me necessary to determine benefits for related services. I agree to pay any amount not covered by my insurance at the time services are rendered and authorized my insurance to pay my doctor directly. I further agree in the event of non-payment to bear the extra cost of in house collection at a rate of **$5 per month**, Transworld collection fee of $50, any court costs, interest at the legal rate and reasonable attorney fees should this collection procedure be required in addition to the amount of the total bill.*

**HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA):** ***By signing below, I also acknowledge that I understand the HIPAA Act and am aware a copy of this office's Notice of Privacy Practices may always be viewed on the office website: middlecreekeyecenter.com.***

**SIGNATURE (Patient/Guardian)X: _____ Date: ____ / ____ / ____**

**Please visit middlecreekeyecenter.com and log into "OUR PATIENT PORTAL" secured site using theUsername and temporary password we will provide as another alternative to reaching us for all your needs. USERNAME: email provided last.first (name) _____**