Date: _____ Tillman Eye Center

First Name: _____ Last Name: _____ Nickname: _____
Birthdate: _____ Age: _____ Email: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip Code (9 digits): _____ Cell Phone: _____
SSN#: _____ Occupation/Place of Work: _____
Reason for Today's Visit: _____
Do you plan to update your glasses: YES or NO Contacts: YES or NO
Are you interested in information on a non-surgical procedure to reduce or eliminate the need for glasses?
YES or NO

Insurance Information: (i.e. VSP, Eyemed, Spectera, SVS, Superior, etc.)
Vision Insurance Company: _____ Subscriber's Name: _____
Subscriber's SS#: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Relationship to Subscriber: _____

Medical Insurance Company: _____ Subscriber's Name: _____
Subscriber's SS#: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Relationship to Subscriber: _____

List of Medications: _____

_____

List allergies to medications: _____
Check all that apply to your relatives: (parents, grandparents, and siblings)
Diabetes _____ Glaucoma _____ Cataracts _____ High Blood Pressure _____
Macular Degeneration _____ Other: _____

Please circle all that apply to YOU:

Blurred Vision	**Vision Fluctuation**	**Tired Eyes**	**Headaches**	**Body Fatigue**
Dry Eyes	**Light Sensitivity**	**Eye Rubbing**	**Poor Night Vision**	**Reduced Concentration**
"Lazy" Eye	**Had LASIK**	**Itchy Eyes**	**Flashes/Floaters**	**Double Vision**
Diabetes	**High Blood Pressure**	**Thyroid**	**High Cholesterol**	**Pregnant**

What are your hobbies? _____

Do you use a smartphone/Tablet computer/Computer? **Yes** or **No**
If yes, how many hours a day do you view the screen? _____ hours/day
Do you like to read books? **Yes** or **No**
If yes, how many hours a day do you spend reading? _____ hours/day
Are you a gamer? **Yes** or **No**
If yes, how many hours a day do you spend gaming? _____ hours/day

* Please complete the following if the patient is a minor *

Father's Name: _____ Work #: _____ Cell #: _____
Mother's Name: _____ Work #: _____ Cell #: _____
Father's Occupation: _____ Mother's Occupation: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

IN ORDER TO ALLOW TILLMAN EYE CENTER TO DISCUSS PATIENT INFORMATION WITH OTHERS INVOLVED IN YOUR TREATMENT OR THE PAYMENT OF SERVICES RENDERED, SUCH AS YOUR SPOUSE, PARENTS, CHILD, RELATIVE, ETC., PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRINTED NAME OF PATIENT_____

BIRTHDATE OF PATIENT_____

ADDRESS_____

PHONE NUMBER_____

I HEREBY ALLOW TILLMAN EYE CENTER TO DISCUSS/RELEASE MY MEDICAL INFORMATION, SUCH AS APPOINTMENT REMINDERS, PICK UP PRESCRIPTIONS, LAB RESULTS, CARE OR TREATMENT NEEDS, ETC., WITH THE FOLLOWING INDIVIDUALS:

1. PERSON TO RECEIVE INFORMATION_____

   STREET ADDRESS/CITY/STATE/ZIP CODE_____

   _____

   RELATIONSHIP TO PATIENT_____

   SIGNATURE OF RECIPIENT_____**DATE**_____

2. PERSON TO RECEIVE INFORMATION_____

   STREET ADDRESS/CITY/STATE/ZIP CODE_____

   _____

   RELATIONSHIP TO PATIENT_____

   SIGNATURE OF RECIPIENT_____**DATE**_____

MY SIGNATURE BELOW INDICATES I UNDERSTAND THE FOLLOWING:

I MAY CHANGE THE NAMES OF THE INDIVIDUALS LISTED ABOVE AT ANY TIME. CHANGES MUST BE MADE IN WRITING. THIS INFORMATION APPLIES TO ALL DEPARTMENTS OF TILLMAN EYE CENTER OF WHICH I MAY BE A PATIENT.

SIGNED SIGNATURE BY PATIENT_____**DATE**_____

Tillman Eye Center **Patient Financial Responsibility Agreement**

Patient Acknowledgement Regarding Financial Responsibility

In order for us to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the patient's obligations and how to meet them. In exchange for services rendered, each patient or patient's guarantor agrees:

*To authorize payment of medical benefits to us, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVII, and or XIX of the Social Security Act is correct.

*To pay for all non-covered charges, co-pays, co-insurance, deductible, out-of-network charges, and refractions (the measurement of the eye in order to obtain a prescription for glasses or contacts) at the time of service or when otherwise advised. If we have to send you a statement for your copay you may incur a processing fee.

Refraction fee: $38.00

Contact Lens Fitting Fee: Varies depending on the type of contact lens you request or the type of contact necessary to provide you the best possible vision. This fee is collected in addition to the fee for an eye examination.

*To provide us with a copy of your most recent insurance card or other proof of insurance and/or register with the receptionist at the time of **EACH** visit. If you do not provide us with valid insurance information at the time of **EACH** visit, and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.

As a courtesy to our self-pay patients seeking routine eye care, we will provide a reduced charge of a **20% discount** made at the time of service. **The entire balance must be paid in full to receive the discount**. Once you accept the discount, we will not be responsible for filing claims to any insurance company nor will we accept payment on a discounted rate from the insurance company. In the event we receive a payment from an insurance company under this circumstance, we will refund the money to the insurance company.

As the patient or guarantor of a patient, I agree that in consideration of the services rendered by us, that I am individually obligated to pay for all services in accordance with the regular rates, terms and conditions of Tillman Eye Center. In the event we must refer the patient's account to a collection agency or attorney for collection of an amount 90 days or older, the patient and/or guarantor agrees to pay our collection fee, including any accrued interest and all applicable bank fees incurred for a returned check.

Medical testing will be part of your comprehensive eye examination. This is necessary to check the health of your eyes. Although this testing is not covered by vision insurance, the test or tests will be filed through your medical insurance. This may result in another copayment, a percentage, or payment in full if the deductible has not been met.

If you have VSP insurance or EyeMed insurance, your plan offers you a discount of a $39.00 copayment on your photos instead of $70.00, or if you prefer to file it on your medical insurance, it may result in you having to pay the full $70.00 if your deductibles have not been met. We will notify you as soon as the claim pays.

I voluntarily consent to healthcare treatment from Tillman Eye Center. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding the results of treatment or examinations by my provider. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

_____ **Date**_____

Patient or Guarantor Signature

TILLMAN EYE CENTER

PATIENT ACKNOWLEDGEMENT
RECEIPT OF PRIVACY NOTICE

I, _____ hereby affirm that a copy of the Notice of Privacy Practices from Tillman Eye Center has been presented to me and a copy is available upon request. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have been presented with a copy of the Notice and a copy is available upon request, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Name of Patient or Legal Guardian

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

Your overall health can play a major factor in the health of your eye. Dr. Tillman may need to request health information from other physicians in order to better monitor you eye health. If you have a primary care doctor we can request your information from please list their information below. ***If you are a diabetic patient, please list the doctor who monitors this condition.**

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

Reason for Records Release: (Office Use Only) _____

Patient's Name: _____

Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Phone Number: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. I may accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____

Patient's Signature Today's Date

_____ _____

Patient's Parent/Guardian/Representative Relationship to Patient