NEW PATIENT REGISTRATION FORM

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PATIENT INFORMATION

Patient's Last Name:	**First:**	**MI:**	**Nickname:**
Home Address:	**City, State, Zip:**		

Phone: (check preferred)
□ Home: □ Cell: □ Work: Ext:

Email Address:	**DOB:**	**Sex:** □ M □ F	**Marital Status:** □ Single □ Married □ Other
Billing Address (if different):			**SSN:**

Employer/School:	**Occupation/Grade:**	**Parent's/guardian's name if patient is a minor:**

In case of emergency, we may contact: **Relationship to patient:** **Phone:**

Why did you choose TFEC? □ Website □ Location □ Google □ Insurance □ Other:	**Preferred Language:** □ English □ Spanish □ Other:
Race: □ Asian □ Black/African American □ Pacific Islander □ Native American/Alaskan □ White □ Decline	**Ethnicity:** □ Not Hispanic or Latino □ Hispanic or Latino □ Decline

MEDICAL HISTORY

Primary Physician & Phone Number:	**Name and location of your pharmacy:**
When was your last eye exam? **Previous eye doctor:**	Do you wear any of the following? □ Glasses □ Contact Lenses Have you been prescribed glasses? □ Yes □ No Are you interested in Contact Lenses? □ Yes □ No
Do you live alone? □ Yes □ No □ Assisted Living □ Nursing Home	**Check if applicable:** □ I am pregnant □ I am nursing
Smoking history: □ Never □ Former Smoker □ Some days □ Every day *If you are a former smoker, when did you quit?*	**Alcohol use:** □ None □ Occasional □ Social □ 1 drink/day □ 2+drinks/day

GENERAL EYE/MEDICAL HISTORY * *Check any conditions that apply: (If you marked yourself or yes, please include the year you were diagnosed)*

	You	Mom	Dad	Sib	N/A	Year Diagnosed		Yes	No	Describe/Year Diagnosed
Glaucoma	□	□	□	□	□		Liver disease	□	□	
Macular Degeneration	□	□	□	□	□		Herpes simplex/Shingles	□	□	
Retinal Detachment	□	□	□	□	□		IBS/gastrointestinal issues	□	□	
Cataracts	□	□	□	□	□		Arthritis	□	□	
Amblyopia/Lazy Eye	□	□	□	□	□		Thyroid Cancer	□	□	
Hypertension	□	□	□	□	□		Kidney Disease	□	□	
Cardiovascular disease	□	□	□	□	□		Rashes/Hives	□	□	
Cancer	□	□	□	□	□		AIDs/HIV	□	□	
Diabetes	□	□	□	□	□		Asthma	□	□	
If **YOU** are a diabetic, what was your last A1C level?							Autoimmune disorder	□	□	

Other medical/eye conditions:

List any major medical/eye injuries and surgeries (*please include estimated date*):

PLEASE LIST CURRENT MEDICATIONS (INCLUDING SUPPLEMENTS & OTC DRUGS), & ANY KNOWN ALLERGIES ON THE BACK OF THIS PAGE.

CURRENT MEDICATIONS	ALLERGIES

OTHER INFORMATION YOU WOULD LIKE US TO KNOW

FINANCIAL & INSURANCE POLICY

**** PLEASE READ ****

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INSURANCE, REFERRALS, NON-COVERED SERVICES & SELF PAY

We will attempt to verify your plan eligibility for services and/or materials before your appointment. Verification of benefits is provided as a courtesy only and is not a guarantee of coverage or payment. It is your responsibility to know your insurance benefits and requirements, including if any benefits require a referral or pre-authorization. If your plan requires a referral or pre-authorization, you must provide and coordinate referrals to us from your primary care physician or confirm that we have obtained this requirement prior to your appointment. If any referrals or pre-authorizations are incomplete, the cost of these services may become your responsibility.

All applicable copays are due at the time of service. Deductibles, coinsurance, and any non-covered services may also be due at the time of service.

If we do not participate in your insurance plan, or if you do not have health or vision insurance, payment must be made in full at the time of service. If we are unable to verify your insurance plan eligibility, your account will remain self-pay and you will be required to make payment at the time of service. A driver's license or other identification will be required for all self-pay accounts. If you are a self-pay patient and pay in full at the time of service, you will receive a 20% discount on the services at your office visit (excludes optical and contact lens purchases). If applicable, we will supply you with a receipt that you can submit to your insurance for reimbursement.

GLASSES, CONTACT LENSES & OTHER MATERIALS

Full payment is due before ordering any glasses frames, glasses lenses, contact lenses, or other optical materials. If any insurance(s) are being used toward the purchase of any covered materials, 100% of the remaining patient obligation must also be paid before any materials will be ordered. Returns, cancellations, and exchanges are subject to specific terms and conditions and may incur a restocking fee. Additional prescription and remake policies are available on our website.

Reasonable attempts will be made to contact you for pick-up when materials have been received; however, you are ultimately responsible for arranging pick-up of any ordered or purchased items. TFEC cannot be held responsible for disconnected phone numbers, clerical errors, or other impediments to contacting you or your responsible party in a reasonable manner. TFEC may, at its sole discretion, attempt to mail to you any items which have been paid for in full. However, TFEC is under no obligation to do so, and may charge you for any associated shipping and handling fees incurred in so doing.

Any materials that have been ordered will be held for no more than 90 days from the original order date. If materials are not claimed within 90 days, any glasses frames, contact lenses, or other materials may be: returned to the manufacturer for any eligible refunds, returned to TFEC inventory, or disposed of. Any unclaimed materials will be returned or disposed of 90 days after the original order date, and you will still be responsible for the payment in full.

APPOINTMENT POLICY

We strive to provide excellent care to all our patients. Please give our office at least 24-hour notice if you need to reschedule or cancel your appointment. If you do not provide us with at least 24-hour notice or you do not show up for your scheduled appointment, you may be charged a $50 rescheduling fee. This fee will not be billed to your insurance company.

FINANCIAL RESPONSIBILITY

Your balance is due in full upon receipt of your monthly statement. This includes coinsurance, deductible, services not covered by your insurance policy and any unpaid services. If necessary, our Billing Coordinator will make several attempts to resolve your unpaid claim. You are responsible, however, for working with your health insurance company should they request additional information from you for claims to be paid. Failure to make your payment in full, or as arranged, may impact your healthcare services' relationship with Tallmadge Family Eye Care, LLC, and your physician.

We gladly accept cash, checks, Visa, MasterCard, Discover, CareCredit and other forms of electronic payment. For each returned, NSF check, our fee is $45.00. If we receive an NSF check, we will not accept another personal check from you until the NSF fees are paid and a payment for the returned check has been made. If we receive two (2) returned checks on your account, we will no longer accept personal checks from you.

Patient/guarantor credits will be refunded in accordance with the policies established by our Billing Department.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

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**** PLEASE READ ****

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected. The privacy rule was created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and sharing with others health information regarding treatment, payment, and healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide only the minimum necessary information to those we feel need your information in order to provide the care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with others (for example a laboratory) and may have to disclose personal health information for the purposes of treatment, payment, or healthcare operations. These partners in your healthcare are also most often not required to obtain patient consent.

You may refuse consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

If you choose to give consent, at some future time you may request to refuse to release all or part of your PHI. You may not revoke your decisions that have already been taken which relied on this or a previously signed consent.

Our **Notice of Privacy Practices** describes in detail how medical information about you may be used or shared and how you can get access to the information. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. If you have any questions or objections to this form, please ask to speak with the Office Manager or our HIPAA Privacy Officer.

PATIENT AGREEMENT & CONSENT FORM

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PUPIL DILATION CONSENT

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes. This allows a better examination of the eyes' internal structures. Thorough examination of these structures is necessary to rule out various eye diseases or pathology. The pupils are simply an entryway or opening to the inside of the eyes. Looking through an *undilated* pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eyes.

A dilated retinal examination is recommended routinely at the time of your comprehensive eye examination, or at other intervals as advised by your eye doctor. Dilation of the pupil causes temporary sensitivity to light and blurring of near vision in most individuals. Blurring of the distance vision may occur as well in individuals with uncorrected farsightedness. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. Dark glasses will be provided after your examination to aid with the light sensitivity.

☐ **CONSENT:** I consent to have my pupils dilated at this time, if in accordance with the recommendations of my doctor. I understand that this service is included in the price of the examination, and **NO EXTRA CHARGE** will be assessed.

☐ **REFUSAL:** I refuse to have my pupils dilated at this time. **I understand that my ocular health cannot be thoroughly evaluated without pupil dilation.**

FINANCIAL RESPONSIBILITY & INSURANCE

Most vision plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems (conjunctivitis, dry eye, ocular injury, cataracts, glaucoma, macular degeneration, sudden pain or vision loss, monitoring for ocular side effects of chronic diseases, etc.) fall under your medical insurance coverage, not your vision plan. Some plans will apply your benefits toward medical copay and deductibles, and some do not. If you have any questions about your coverage, be sure to contact your insurance company prior to your appointment. Insurance benefits quoted during your visit are not a guarantee of coverage.

You have _____ as your routine vision plan.

Ask an optician how to use your benefits toward new glasses or contact lenses.

*** In Office Use Only ***

Your vision plan contributes $_____ toward a new frame.

Your vision plan contributes $_____ toward contact lenses.

*** In Office Use Only ***

☐ I have read and understand the TFEC Financial & Insurance Policy. If I have medical or routine vision benefits, I agree to assign applicable insurance benefits to TFEC whenever necessary and authorize TFEC to release any information required for payment to be made. I understand that insurance benefits, copays, and prices quoted during my visit are not a guarantee of coverage.

PRIVACY PRACTICES & CONSENT

The Department of Health and Human Services has established a Privacy Rule to help ensure that personal healthcare information (PHI) is protected. The Privacy Rule was created in order to provide a standard for certain healthcare providers to obtain their patient's consent for use and sharing with other providers health information regarding treatment, payment, and healthcare operations. As our patient, we want you to know that we respect the privacy of your PHI and will do all that we can to secure and protect it. When appropriate and necessary, we provide only the minimum necessary information to those we feel need your information in order to provide the care that is in your best interest. We support your full access to your personal medical records.

☐ I have read the information sheet regarding the TFEC Notice of Privacy Practices (Patient Acknowledgement of the Notice of Privacy Practices) and understand how Tallmadge Family Eye Care can use my Personal Health Information (PHI). I have been given the opportunity to review the TFEC Notice of Privacy Practices. I consent to the use of my PHI and acknowledge that I can request restrictions and revoke consent for the use of my PHI in writing at any time after reviewing the Privacy Notice.

TEXT-TO-PAY/ELECTRONIC STATEMENT AGREEMENT

Our Text-to-Pay feature is a free, secure, and convenient way for you to receive statements and make payments all from your mobile device. When you have an outstanding balance, we will send you a text message with a secure link that allows you to view your statement and make your payment all at the same time. Accepted payment methods include all major credit cards, Google Pay, Apple Pay, Link, and more.

☐ **YES**, I would like to receive a paperless statement and make payments for my outstanding balances on my mobile device.

☐ **NO**, I would like to receive a paper copy of my statement in the mail. I do not want to make payments on my mobile device.

_____	_____	_____
Patient/Legal Guardian Name (Printed)	**Patient/Legal Guardian Signature**	**Date**