



Paul C. Tisdal, OD Jaclyn A. Munson, OD

"Welcome to our family of patients! Take a moment and tell us all about you. Sit back, relax, and let us take it from here. Our team is ready to provide customized vision care for you and your family."

Please provide MEDICAL and VISION insurance card(s) upon registration. Please provide a copy of your current vitamin/medication list upon registration.

Dr. Mr. Mrs. Ms. Miss First Name: Last Name: Middle Initial:

Date of Birth: / / Age: Gender: M / F SS#: - -

Cell Phone: - - Home Phone: - - Email:

Address City: State: Zip:

Grade in School: Occupation: Employer:

Emergency Contact: (name) (relationship) (cell phone number)

The following individual(s) are allowed access to my health care records and private health information:

First Name: Last Name: Relationship: Cell Phone: - -

Address: City: State: Zip:

First Name: Last Name: Relationship: Cell Phone: - -

Address: City: State: Zip:

Tell us the most important wish to change about your vision performance

What are you interested in? LASIK Implantable Contact Lenses Cataract Surgery other

What should your fashion eyewear say about you? "I am" Athletic Casual Professional Trendy

Problem with current glasses? No problems! I love my current glasses

How many digital devices do you use? Have you ever tried digital computer glasses? Yes Tell me more

Preferred contact lenses replacement schedule? Daily Monthly Extended Wear No thanks, maybe later

Do you protect your eyes with polarized sunwear? Yes No Hobbies?

How did you hear about our quality of care?

Share your fond impressions of the Weatherford Eyecare Center with a post-appointment survey. Check your email. Check out our website at www.visionsource-weatherford.com for the latest news in eye care. Add us to your favorites!

Notice of Privacy Practices

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notices while it is in effect. This Notice takes effect August 1, 2014 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted applicable by law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing your treatment.

Payment: We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company, or third party for the treatment and services received. For example, we may give your health plan information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved with Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, text message, or letters).

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Special Circumstances

Required by Law: We may use or disclose your health information when we are required to do so by law.

Business Associates: We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

National Security: We may disclose to military authorize the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Military and Veterans: If you are a member of the armed forces, we may release health information as required by military command authorities. We also may release health information to the appropriate foreign military authority if you are a member of a foreign military.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspect abuse or neglect, non-accidental physical injuries, reactions to medication or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved with a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We also may disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Inmates or Individual in Custody: If you are an inmate of the correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official.

Patient's Rights

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will follow Oklahoma Statute Title 76 Section 19 in reference to changes).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 3 years, but not before January 1, 2011. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Out-of-Pocket Payments: If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operation, and will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may address to file your complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We support your right the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Joy Warren Telephone: (580) 772-2819 Fax: (580) 772-2805 Address: 1545 Washington Street, Weatherford, OK 73096



Financial Policy

“Thank you for taking the time to read our financial policy. If you have additional questions our Insurance & Billing Specialists are always available for consultation. We are happy to help guide you through the maze of insurances.”

PAYMENT

For all medical services and eye exams, the co-payment and/or deductible is due on the date of service. For glasses, contact lenses, and accessories provided by the Weatherford Eyecare Center ½ payment must be paid at the time of the order is placed. The balance is due on delivery. We accept cash, personal checks, credit cards, and care credit.

INSURANCE

At each visit to the Weatherford Eyecare Center, we will need a copy of all of your current insurance card(s) if you have had any changes to your insurance. **As a courtesy**, we will bill your insurance company for the covered services provided to you. Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of the benefit information given to us by insurance companies. If for some reason your insurance company fails to pay, you will be expected to pay the balance in full within 60 days. If you have not met the deductible amount for the year, and the insurance company applies your covered charges to your annual deductible you will be billed for the amount of the service(s). **You will be billed for all charges that are denied by your insurer due to no authorization or for us being out of network.** If insurance information, including copies of your cards, is not provided on the day of service, you may be responsible for filing the claim yourself.

NON-COVERED SERVICES

Insurance regulations suggest that we inform you in advance if a service may not be covered or fully reimbursed by your insurance carrier. A non-exhaustive listing of possible non-covered services includes: refractions, topography, eye photography, eye imaging, visual field testing, lab cultures, eye pharmaceuticals, eyewear, contact lenses and solutions, eye supplements, etc.

MEDICARE

For patients who have Medicare, you must have **Part B** coverage for Medicare to pay your claim. You will be responsible for any charges Medicare or your supplemental insurance does not cover. This may include, but is not limited too; deductibles, refractions, eyewear, and other testing our physicians may order.

NON-INSURANCE

For patients without insurance, payment is due at the time service is rendered.

PRODUCT

A 50% deposit is due at the time materials are ordered. The remaining balance is due at the dispensing of materials. This office is not responsible for any material(s) left after 90 days. Deposits are non-refundable.

LATE FEE

A late fee of \$25.00 will be added to your balance when the account is 60 days past due.

I (print patient name) _____ have read, understand, and agree to the conditions above. I have been informed in advance of the potential for non-covered services to protect my eyesight. I have advised the doctors to proceed with such services, whether or not they are covered by my insurance. I agree to be personally and fully responsible for payment. I acknowledge that I reviewed a copy of the Weatherford Eyecare Center’s Notices of Privacy Practices. By signing below, I authorize the release of any medical or other information necessary to process my insurance claims and transfer records.

X _____ Today’s Date: ____ / ____ / ____
Patient Signature (or Guardian if patient is a minor)

Please return this completed section to the reception team for review.
Continue to the next section.



Patient's Health History

Today's Date _____ / _____ / _____

Patient First Name: _____ Last Name: _____ Middle Initial: _____ Date of Birth: ____/____/____

General Care Provider _____ MD / DO / Other _____ Location _____

Allergies to Medications _____ Preferred Pharmacy _____

Your Eye Symptoms

Burning Eyes	N	Y	RT/LT/BOTH	Flash(es)	N	Y	RT/LT/BOTH	Itchy Eyes	N	Y	RT/LT/BOTH
Discharge, Color	N	Y	RT/LT/BOTH	Floater(s)	N	Y	RT/LT/BOTH	Light Sensitive	N	Y	RT/LT/BOTH
Double Vision	N	Y	RT/LT/BOTH	Glare	N	Y	RT/LT/BOTH	Redness	N	Y	RT/LT/BOTH
Eye Infection	N	Y	RT/LT/BOTH	Gritty Eyes	N	Y	RT/LT/BOTH	Tired Eyes	N	Y	RT/LT/BOTH
Eye Pain/Sore	N	Y	RT/LT/BOTH	Halos/Distortion	N	Y	RT/LT/BOTH	Watery Eyes	N	Y	RT/LT/BOTH

Your Eye History

			<u>Specialist</u> _____	<u>Next Follow up</u> _____
Blindness	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Cataract	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Color Blindness	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Crossed Eyes	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Diabetic Eye Disease	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Foreign Object Removal	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Glaucoma	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Macular Degeneration	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Retinal Detachment	N	Y	RT/LT/BOTH Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Other _____			RT/LT/BOTH Medications/Surgery _____	

Your Allergy History

			<u>Specialist</u> _____	<u>Next Follow up</u> _____
Environmental Allergies	N	Y	Specify _____ Medications/Surgery _____	
Collagen/Silicone	N	Y	Specify _____ Medications/Surgery _____	
Metal/Nickel	N	Y	Specify _____ Medications/Surgery _____	
Other _____			Specify _____ Medications/Surgery _____	

Your History of Cancer

Type _____	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Other _____			Medications/Surgery _____	

Your Cardiovascular History

			<u>Specialist</u> _____	<u>Next Follow up</u> _____
Blood Clot / Thrombosis	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Elevated Cholesterol	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
High or Low Blood Pressure	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Murmur / Palpitations	N	Y	Medications/Surgery _____	Family? Mother/Father/Sibling/Grandparent _____
Other _____			Medications/Surgery _____	

Constitutional

			<u>Specialist</u> _____	<u>Next Follow up</u> _____
Fever	N	Y	Medications/Surgery _____	
Weight Loss or Gain	N	Y	Medications/Surgery _____	Exercise? Diet? Portion Control? _____
Other _____			Medications/Surgery _____	

Your Endocrine History

Specialist _____ **Next Follow up** _____

Crohn's Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Diabetes N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Type? _____ How long? _____ A₁C _____ Avg. FBS _____ Check How Often? _____

High or Low Blood Sugar N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

High or Low Thyroid N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Gastrointestinal History

Specialist _____ **Next Follow up** _____

Acid Reflux N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Diverticulosis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Gall Bladder N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Ulcer N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Genitourinary History

Specialist _____ **Next Follow up** _____

Are you Pregnant? N Y # of Weeks _____ Complications? _____ Medications _____

Birth Control N Y Medications/Surgery _____

Bladder / Kidney N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Prostate N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Transmitted Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Ear/Nose/Throat History

Specialist _____ **Next Follow up** _____

Dry Throat / Mouth N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Seasonal Allergies N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Sinus Congestion N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Blood/Lymph History

Specialist _____ **Next Follow up** _____

Anemia N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Bleeding Problems N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Hepatitis Type _____ N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Transfusion / Dialysis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Immune History

Specialist _____ **Next Follow up** _____

Autoimmune Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Lupus N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Sjogren's N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Skin History

Specialist _____ **Next Follow up** _____

Psoriasis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Rosacea N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Melanoma(s) N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Suspicious Lesion(s) N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Bone/Joint/Muscle History **Specialist** _____ **Next Follow up** _____

Muscle Pain N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Neck Pain N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Juvenile Arthritis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Osteo Arthritis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Rheumatoid Arthritis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Neurological History **Specialist** _____ **Next Follow up** _____

Headache N Y Location _____ How Often? _____ Wake you up at night? _____
 How does vision change? _____ Medications/Surgery/MRI/CT _____

Migraine N Y Location _____ How Often? _____ Wake you up at night? _____
 How does vision change? _____ Medications/Surgery/MRI/CT _____

Seizure(s) N Y At what age? _____ Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____
 How does vision change? _____ Medications/Surgery/MRI/CT _____

Stroke N Y At what age? _____ Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____
 How has vision changed? _____ Medications/Surgery/MRI/CT _____

Other _____ Medications/Surgery _____

Your Psychiatric History **Specialist** _____ **Next Follow up** _____

ADD/ADHD N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Alzheimer's Disease N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Anxiety N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Dementia N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Depression N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Spectrum Condition N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Your Respiratory History **Specialist** _____ **Next Follow up** _____

Apnea, Sleep N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Asthma N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Chronic Bronchitis N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

COPD N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Emphysema N Y Medications/Surgery _____ Family? Mother/Father/Sibling/Grandparent _____

Other _____ Medications/Surgery _____

Social History How often do you use? Cigarettes _____ Tobacco _____ E-Vape _____

What other substances do you use? _____ How often do you consume alcohol? Never Socially Often

Thank you for sharing your confidential health information. Please return this completed section to the reception team.