WEATHERFORD EYECARE CENTER

Paul C. Tisdal, O.D. • Jimmy Smart, O.D.

"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.

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone Type

Phone 2, Type

E-mail

Preferred Contact Method *cell phone | e-mail | text | other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time | part-time*

Marital Status *married | single | divorced | legally separated | widowed*

Language, Race, Ethnicity Referral:

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse | child | other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy#/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

WEATHERFORD EYECARE CENTER

Name: _____

Date of Birth: _____

Pharmacy: _____

Primary Care Physician: _____

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

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

Dr. Jimmy D. Smart O.D. DR. PAUL C. TISDAL O.D.

PATIENT INFORMATION

CONSENT FOR MEDICAL RELEASE

AND OR PICK UP OF GLASSES OR CONTACTS

I, (patient's name) _____ give my permission for the undersigned to have access to my medical records and/or to pick up glasses and/or contacts.

Signature_____

1._____relation _____

2._____relation _____

3._____relation _____

WEATHERFORD
EYECARE CENTER

CONSENT FOR DILATION EYE DROP

WHILE UNDER THE CARE OF DR. JIMMY SMART AND DR. PAUL TISDAL

A variety of eye drops maybe administered during the course of your eye examination. Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of the time will be blurred and the degree of eyesight impairment varies from person to person. It is not possible for your doctor to predict how much or how long your vision will be affected. Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards.

Instead, we strongly suggest you make arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Although uncommon, the potential for adverse reaction from eye drops does exist, such acute angle-closure glaucoma, which may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

You herby authorize Dr. Tisdal and/or assistants to administer dilation eyedrops or other eye drops during the course of your treatment. You understand that these eye drops are necessary to diagnose your condition. You further understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

_____ _____

Patient (or patient's authorized representative) Date

WEATHERFORD
EYECARE CENTER

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME_____

I request that payment of authorized Insurance benefits be made on my behalf to Weatherford Eyecare Center for any service furnished to me by a physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents or any other insurances, any information needed to determine these benefits payable for related services. In Insurances assigned cases, the provider agrees to accept the charge determination of the Insurance carrier and I am responsible for the Insurance deductible, co-insurance or the 20% Insurance does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Insurance Benefits have been relinquished.

SIGNATURE_____**DATE**_____

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Weatherford Eyecare Center, or any physician, for services provided to me by the physician. I authorize any holder of medical information about me to release it to my Medigap insurer_____ _____, or any information needed to determine these benefits payable for related services.

The assignment shall remain in effect until revoked by me in writing. A photo copy of this assignment is considered as valid as the original. I am responsible for any co-pays, co-insurance, deductible or any non-covered services.

SIGNATURE_____**DATE**_____

WEATHERFORD EYECARE CENTER

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."

MEDICAL & VISION INSURANCE

What's the Difference?

Medical insurance must be used if you have any eye health problem, minor surgical procedure(s) performed, or if you have a systemic health problem that has ocular complications. Dr. Tisdal will determine if these conditions apply to you; some are determined by your case history. If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other.

Vision care plans or "discount plans" only contribute partial payment toward one basic vision exam and contribute partial payment toward rebate frames, lenses, and contact lenses. Vision plans do not cover diagnosis, management or treatment of eye diseases that Dr. Tisdal is specifically educated and trained to watch for on your behalf. In most cases, additional visits are necessary to coordinate your care and protect your vision.

At each visit to the Weatherford Eyecare Center a copy of your current insurance card(s) will be requested. **As a courtesy**, we will bill your insurance company for the services provided to you. Most insurance policies contribute 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.

PAYMENT

For all medical services and eye exams, the co-payment and/or deductible is due on the date of service. Minor surgical fees are due in full at the time services are rendered. For glasses, contact lenses, and accessories purchased at the Weatherford Eyecare Center a minimum of 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.

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. We will do our best to communicate with you.

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)

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 much 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 to 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