Tillamook Vision Center

800 Main Ave, Suite A
Tillamook, OR 97141
Phone: 503-842-5568

Thank you for choosing our office! Please complete all pages of this form in ink. If you have any questions, please contact us. We'll be happy to help you!

_____ _____ _____
Last Name First Name Middle Initial Preferred Name Date of Birth

Sex: ☐M ☐F Street Address: _____

City: _____ State:_____ Zip:_____

Mailing Address_____

City: _____ State:_____ Zip:_____

E-mail Address: _____

Primary Phone: _____ Is this your Cell, Home, Work, or Message? _____

Secondary Phone: _____ Is this your Cell, Home, Work, or Message? _____

Note: we confirm all appointments via text or email. Which is your preference? ☐Text ☐Email

Employer: _____ Occupation: _____

Emergency Contact Name: _____Date of Birth_____

Relationship to you: _____Phone: _____

(Note: if you would like to add more emergency contacts, please add them on a separate sheet of paper.)

If the patient is a child, please complete the next section:

Mother's First Name_____ **Mother's Last Name**_____

Date of Birth _____ **Cell Phone** _____ **Work Phone** _____

Employer _____ **Occupation** _____

Father's First Name_____ **Father's Last Name** _____

Date of Birth _____ **Cell Phone** _____ **Work Phone** _____

Employer _____ **Occupation** _____

Financial Account Guarantor _____
Last Name, First Name, Middle Initial

Guarantor's Relationship to Patient _____**Guarantor's Date of Birth**_____

►I authorize my insurance company to pay the doctor all insurance benefits for services rendered.
►I authorize the use of this signature on all insurance submissions.
►I authorize the doctor to release all information necessary to secure the payment of benefits.
►If applicable, I authorize release of my child's exam results to his/her school.
My signature below provides long term authorization until my written notice otherwise.

_____ _____
Patient Signature Date

-OR-

_____ _____ _____
Patient Representative Signature Description of Representative's Authority Date

TILLAMOOK VISION CENTER FINANCIAL POLICY

We are pleased to discuss our fees with you at any time. Your clear understanding of the financial policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your responsibility.

- **Full payment for examination fees is due at time of service.**
- For patients without vision insurance a 50% deposit of the total materials fee is required when materials are ordered, and the balance is due when materials are picked up.
- **We accept cash, checks, Visa, MasterCard, Discover, American Express, CareCredit, and debit cards.**

If you have insurance, we will help you receive maximum benefits. We submit claims directly to most insurance companies. If we are billing insurance for you, you can expect to pay your co-payment at the time of service.

If your insurance company has not paid the full balance within 45 days, you will be expected to pay the remaining balance.

If you are covered by an insurance company that we don't directly bill, you will need to submit the claim yourself. You can expect to pay for your fees in full at the time of service, and your insurer will reimburse you.

Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

We ask that you give 24 hours notice if you are unable to keep your appointment. Patients who fail to give 24 hours notice will be assessed a missed appointment fee.

A service charge of 1.5% or $1.00 minimum per month will be applied to unpaid accounts after 60 days from the date of service. A late charge will be assessed to delinquent accounts.

I have read and understand the financial policy. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____	_____	_____
Print Patient Name	Patient Signature	Date

-OR-

_____	_____	_____
Patient Representative Signature	Description of Representative's Authority	Date

Tillamook
Vision Center

Acknowledgment and Consent

I understand that Lee Johnson, O.D. of Tillamook Vision Center, TVC OD LLC (referred to below as "this Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- and perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date: _____
(Patient representative)

Description of Representative's Authority:_____

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Note: In order to provide you with the best possible benefit, we need your medical insurance information in addition to your vision insurance information.
Please bring your current insurance cards to your next appointment.

PRIMARY MEDICAL INSURANCE:

Insurance Company: _____

Member ID#: _____Group#: _____

If subscriber is different from you (the patient), please enter the following information:

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____

Subscriber Phone: _____Subscriber Employer: _____

SECONDARY MEDICAL INSURANCE

Insurance Company: _____

Member ID#: _____Group#: _____

If subscriber is different from you (the patient), please enter the following information:

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____

Subscriber Phone: _____Subscriber Employer: _____

VISION INSURANCE:

Insurance Company: _____

Member ID#: _____Group#: _____

If subscriber is different from you (the patient), please enter the following information:

Subscriber Name: _____ Subscriber Date of Birth: _____

Last Four of Subscriber's SSN (used to look up benefits): _____

Subscriber Address: _____

Subscriber Phone: _____Subscriber Employer: _____

Tillamook Vision Center Medical History Questionnaire

Patient Name _____ Birthdate _____
Do you currently wear glasses? ___All the time ___Occasionally ___No
Do you wear contact lenses? ___All the time ___Occasionally ___No ___Worn in the past ___Interested in contact lenses
Have you had any eye injuries? Yes / No Describe: _____
Have you had any eye surgeries? Yes / No Describe: _____
Do you drive? Yes / No If yes, do you have visual difficulty driving? Yes / No

Have you been diagnosed with:
Y N Cataract
Y N Macular Degeneration
Y N Glaucoma
Y N Diabetes
Y N Diabetic Retinopathy
Y N Dry Eye
Y N Eye Infection / Inflammation
Y N Floaters and/or Flashes of Light
Y N Iritis or Uveitis
Y N Retina Defects / Degeneration
Other: _____

Do your eyes have:
Y N Redness
Y N Burning
Y N Itching
Y N Tearing
Y N Discharge
Other: _____

Do you have:
Y N Blurred Vision
Y N Eyestrain
Y N Eye Pain
Y N Severe Sensitivity to Light
Y N Headache
Y N Poor Night Vision
Y N Bothersome Night Glare
Y N Double Vision
Y N Total Loss of Vision
Other: _____

Do you use:
Y N Alcohol - How much _____
Y N Tobacco - How much _____

Family History: Circle member affected
F: Father, M: Mother S: Son, D: Daughter

Y N	**Type 2 Diabetes**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Hypertension**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Macular Degeneration**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Glaucoma**					
	F	**M**	**Bro**	**Sis**	**S**	**D**

Do you have the following:
Y: Yes, **N**: No, **P**: Past

Constitutional:
Y N P Fatigue Syndrome
Y N P Cancer – Type: _____

(ENT) Ear Nose Throat:
Y N P Hearing Loss
Y N P Sinusitis
Y N P Dry Mouth
Y N P Laryngitis

Neurological:
Y N P Multiple Sclerosis
Y N P Epilepsy
Y N P Cerebral Palsy
Y N P Tumor
Y N P Migraine

Psychiatric:
Y N P Depression
Y N P Attention Deficit
Y N P Anxiety Disorder
Y N P Bipolar Disorder

Cardiovascular:
Y N P High Blood Pressure
Y N P Stroke / CVA
Y N P Heart Disease
Y N P Vascular Disease
Y N P Congestive Heart Failure

Respiratory:
Y N P Asthma
Y N P Bronchitis
Y N P Emphysema
Y N P Chronic Obstruction
Y N P Sleep Apnea

Gatrointestinal:
Y N P Crohn's Disease
Y N P Colitis
Y N P Ulcer
Y N P Acid Reflux
Y N P Celiac Disease

Genitourniary:
Y N P Kidney Disease
Y N P Prostate Disease / Cancer
Y N P STD
Y N P Benign Prostate Hypertrophy
Y N Pregnant
Y N Nursing
Y N P Herpes
Y N P Chlamydia

Musculoskeletal:
Y N P Osteoarthritis
Y N P Fibromyalgia
Y N P Muscular Dystrophy
Y N P Ankylosing Spondylitis
Y N P Osteoporosis
Y N P Gout

Integumentary:
Y N P Eczema
Y N P Rosacea
Y N P Psoriasis
Y N P Herpes Simplex / Cold Sores
Y N P Herpes Zoster / Shingles

Endocrine:
Y N P Type 2 Diabetes
Y N P Type 1 Diabetes
Y N P Thyroid Dysfunction
Y N P Hormonal Dysfunction

Hemotologic / Lymphatic:
Y N P Anemia
Y N P High Cholesterol

Immune:
Y N P Rheumatoid Arthritis
Y N P Lupus
Y N P Sjogren's Syndrome

Allergies:
Y N Drug Allergies List:
_____
Y N Environmental Allergies List:
_____
Other: _____

To the best of my knowledge, I have answered these questions accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any change in my medical status.

_____ -or- _____ _____
Patient Signature Guardian Signature Date

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Patient Name: _____ Birthdate: _____

Who is your Primary Doctor?_____
(the provider/PCP/general practitioner you have established care with to see for your general medical needs)

Which Pharmacy do you prefer?_____

Do you take any medications? Yes / No

Patient Medication List: Complete form or bring your pre-printed copy

Medication	Used For	Prescribed By

We know that insurance companies do not always process claims within the legal guidelines. When that happens, we will be happy to file a complaint to the insurance commissioner to get your benefits released. Please sign this letter in the event that claims are unpaid at the prompt payment date on your behalf. Please do not fill in any blanks – only your signature is required at this time. Thank you!

To Whom It May Concern:

My provider filed the attached claim form with _____ on _____. It has not been paid or denied. It is my understanding that there are state prompt payment laws and/or guidelines that monitor commercial insurance carriers. The State Insurance Department regulates these law and/or guidelines. Tillamook Vision Center's staff has advised me that they have attempted to resolve the claim on _____. At this time, reimbursement is still outstanding with little regard to my legitimate rights to have my claim processed within the legal guidelines.

Benefits were assigned to Lee Johnson, OD, and as of today's date, payment has not been received. As a result, I am responsible for payment of this bill.

Please accept this letter as a formal written complaint against _____.

Sincerely,

_____

(Patient signature)