Please complete both sides of this form in ink

Welcome to Tillamook Vision Center

Thank you for choosing our office. If you have questions call 503-842-5568. We'll be happy to help you!

Patient Last Name, **First Name** **Middle Initial** **Preferred Name / Nickname** **Date of Birth** **Age** Sex M / F **Date**

Street Address_____ City_____ State_____ Zip_____

Mailing Address_____ E-mail Address _____
(street or PO Box, city, state, zip if different from above)

Phone: Home _____ Work _____ ext. ____ Cell _____ Message _____

In case of emergency contact _____ Phone _____ Relationship to patient _____

If the patient is an adult, please complete the next section----------

Patient Employer_____ Occupation _____

Spouse / Partner Name _____ Date of Birth _____ Cell Phone _____

S / P Employer _____ Occupation _____ Work Phone _____

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

School attending _____ Grade _____ Teacher/s _____

Mother's Name _____ Date of Birth _____ Cell Phone _____

Employer _____ Occupation _____ Work Phone _____

Father's Name _____ Date of Birth _____ Cell Phone _____

Employer _____ Occupation _____ Work Phone _____

Account Guarantor _____
Last Name, First Name Middle Initial Relationship to Patient

I authorize my insurance company to pay to 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

Please complete both sides of this form in ink

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 -OR-	Date
Patient Representative Signature	Description of Representative's Authority	Date

Meds-MHQ: -med-

Tillamook Vision Center Medical History Questionnaire: Complete both sides of form in ink

Please fill out the information below. Your complete medical history is vital to your doctor to help you maintain good vision and eye health.

Patient Name _____ Birthdate _____ Date_____

Primary Care Provider _____ Pharmacy _____ Do you take any medications? Yes / No

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 which member affected
F=Father, M=Mother, Bro, Sis, 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:
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 Cebebral Palsy
Y / N / P Tumor
Y / N / P Migraine

Pyschiatric:
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 Fail.

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

Gastrointestinal:
Y / N / P Crohn's
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

Muscluoskeletal:
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

Allergic / Immune:
Y / N Drug Allergies List: _____
_____
Y / N Environmental Allergies List: _____
_____
Y / N / P Rheumatoid Arthritis
Y / N / P Lupus
Y / N / P Sjogren's Syndrome

Other:

To the best of my knowledge, I have answered 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

MHQRev 0315

Please complete both sides of this form in ink

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

Patient Name _____ **Date of Birth** _____ **Date** _____

Medication	Used For	Prescribed By

ACKNOWLEDGMENT AND CONSENT

I understand that Eric Halperin, O.D. and Beatrice Michel, O.D. of Tillamook Vision Center, Halperin & Michel ODs PC (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:_____