Patient Information

First Name: _____ MI: _____ Last Name: _____

SS #: _____-_____-_____ Birthdate: _____/_____/_____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail: _____

Occupation: _____ Employer: _____

Primary Medical Dr.: _____ City: _____

Insurance Information

Policy Holder Name: _____ Relationship to Patient: _____

SS #: _____-_____-_____ Birthdate: _____/_____/_____

Person Responsible for Bill: _____

Address (if different): _____ *Apt/Unit #:* _____

City: _____ *State:* _____ *Zip:* _____

Home Phone: (_____) _____-_____ *Cell Phone: (_____)* _____-_____

Fee Schedule:

Examination charges are based on the professional time utilized for each particular procedure. Our physicians require ***retinal photography**** to be done on all patients annually.

This will require an additional charge of $39.00 to your comprehensive examination. *

Payment Policy:

Physician Fee(s):	All professional fees are due on the day services are rendered.
Contacts/Eyeglasses:	Payment is required before ordering.
Credit Card Processing Fee:	**We charge 3% of any balance due for fees processed on a credit or debit card.**

Assignment of Health/Vision Insurance Benefits:

I hereby assign all insurance benefits to Thurmond Eye Center for services rendered in their office. This assignment includes benefits payable to Medicare, Medicaid and all other health/vision insurance programs of which I am beneficiary. I authorize the release of all information from all sources necessary to secure payment for services rendered. The undersigned agrees to be responsible for any charges not covered by the above provided sources.

Patient/Guardian Signature: _____ Date: _____/_____/_____

THURMOND EYE CENTER

Patient Medical History

Name:	DOB:	Age:	Date:
Race: □Caucasian □African American □Hispanic □Asian	Family Medical Doctor:		
Last Eye Exam:	Last Eye Doctor:		
Occupation:	Hobbies:		

Past Medical, Family, Social and Ocular History

Medical History / Review of Systems		
Self		Family
	Arthritis	
	Blood disease (anemia, sickle cell)	
	Ear, Nose, Throat (allergies)	
	GI Disease (ulcers, acid reflux, Crohns)	
	Thyroid Disease	
	Lung Disease (asthma, emphysema)	
	Heart Disease	
	Kidney, Bladder, Genital	
	Diabetes (sugar)	
	High Blood Pressure	
	Neurological Problems (brain, nerves)	
	Skin Disease	
	Mental (depression, anxiety)	
	Cancer	
	Infectious Disease (HIV, hepatitis)	
	Other (list)	
Medications:		

Ocular History		
Self		Family
	Cataracts	
	Glaucoma	
	Macular Degeneration	
	Blindness	
	Lazy Eye/Eye Turn	
	Retinal Disorders	
	Eye Injuries	N/A
	Eye Surgeries	
	Other (list)	
Social History		
Marital Status: □Single □Married □Divorced/Widowed		
Do you live alone? □YES □NO □Assisted Living Fac.		
Do you smoke/use forms of Tobacco? □YES □NO		
If yes, how much/often?		
Do you drink Alcohol? □YES □NO		
If yes, how much/often?		
Drug Allergies:		

Patient Initials / Date	Tech Initials / Date	Dr. Initials / Date

Are you pregnant? □YES □NO

Dr. Sherman Thurmond ◊ Dr. Rhonda Thurmond

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PHI means information about a patient, including but not limited to demographic information that may identify a patient that relates to the patient's past, present, or future, physical or mental health or condition, related healthcare services or payment for health care services.

Person(s) I authorize to receive my PHI:

Name	Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the patient and/or legal guardian, have received a copy of this office's Notice of Privacy Practices.

_____

Print Patient Name

_____ _____

Patient/Legal Guardian Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- — Individual refused to sign
- — Communications barriers prohibited
- — An emergency situation prevented us from obtaining
- — Other: (specify) _____
- —

Contact Lens Agreement

1. All contact lens services are separate from the routine eye exam. The contact exam assesses and monitors issues relevant to the fit and performance of contact lenses and your ocular health. These services are not included in your insurance exam copay. You will be responsible for ALL PROFESSIONAL SERVICES today. After you request a contact lens exam, the fee will **not** be refunded if you choose not to proceed with contact lens wear. **Please initial _____**
2. A corneal topography is required on all new and existing contact lens wearers. This advanced technology is used to ensure the best possible fit of your contact lenses and to assess whether prior contact lens use has caused damage to the ocular surface. This procedure is not covered by insurance. ***The fee for topography is $32***. **Please initial _____**
3. By federal law, all contact lens prescriptions are considered expired twelve (12) months from the date of the last full eye exam. We cannot make exceptions to this, and we ask for your cooperation in this matter. A copy of your contact lens prescription will be available to you once it has been finalized by the doctor. **Please initial _____**
4. Contact lenses are a personal device designed for your individual eyes. Please do not share your lenses or contact lens case with others, as this can spread infection. Furthermore, they cannot be reused or returned for credit once ordered. In the event a patient is unsuccessful at contact lens wear, Thurmond Eye Center will issue an in-office credit for any materials purchased and NOT ordered. **Please initial _____**
5. Your adherence to the instructions and schedules recommended by your doctor and our staff is essential for successful contact lens wear. Any deviation from such recommendations can result in possible lens damage, contamination, intolerance and/or infection. **Please initial _____**
6. Contact Lenses should never be worn when your eye is red or uncomfortable. Redness can be a sign of a serious problem and should be seen by the Doctor without delay. **Please initial _____**
7. Due to present liability laws, the North Carolina Optometry Board does not require our office to release a contact lens prescription to any non-licensed lens distributors. **Please initial _____**

IF YOU HAVE ANY QUESTIONS ABOUT THIS AGREEMENT, PLEASE ASK ANY STAFF MEMBER BEFORE YOUR EXAM.

I have read and understand the above policies. If questions or eye related problems should arise, I will contact the office and seek appropriate medical help. I understand that Thurmond Eye Center has a 24 hour emergency number in which the doctor may be reached at any time. I agree to return for periodic evaluation as recommended by the doctor, and I understand my prescription expires 12 months from the date of last comprehensive eye exam.

Patient Signature: _____ Date: _____

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP, EyeMed, Davis, Superior, CEC, etc.)
    - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnoses, management, or treatment of eye diseases.
2. Medical Insurance (such as BlueCrossBlueShield, United Health Care, etc.)
    - Medical Insurance must be used if you have any eye health problem or systemic health problem that may affect your eyes. Your doctor will determine if these conditions apply to you, but some are determined by your health history as well as risk factors. (Examples: Diabetic Retinopathy, Hypertensive Retinopathy, Glaucoma, Macular Degeneration etc.)

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. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense. We will bill your insurance plan for services if we are a participating provider for that plan. If some fees are not paid by your plan, you are responsible for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

Retinal Photography

As a part of the comprehensive eye exam, our doctors require Retinal Photography.
The imaging fee is $39.
If a medical condition is found, then these photos will be billed to your major medical insurance. Filing initial findings as necessary will help with coverage for additional testing, follow ups, and/or treatments. A co-pay or deductible may apply in lieu of the $39 imaging charge.
Payment is expected at the time of treatment. Any deductibles, co-payments and non-covered services must be paid at the time of visit unless otherwise specified. We will be glad to help you fill out any insurance forms that your plan may require.

No-show, Cancellation, Reschedule Policy

No-Shows, Cancellations or Changes made to an appointment within 24 hours of scheduled time may result in a $25 broken appointment fee. To avoid these charges, please contact us more than 24 hours in advance of your appointment to make any changes necessary. **Three no-shows, or appointment reschedules in a row may result in dismissal of the practice at the discretion of the practice manager.**

*** We charge 3% of any balance due for fees processed on a credit or debit card. ***

Please initial here _____

I have read & agree with the office insurance and scheduling practices.

_____ _____ _____

Print Patient Name Signature (guardian if minor) Date