Turn Over

VISION SOURCE

708 Hill Country Dr., Suite 100
830-257-5656 www.visionsource-tilley.com

Last Name: _____ **First Name:** _____ **MI:** _____ Male / Female

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Cell Phone:** _____ **Is texting okay?** Yes / No

Email: _____ **Date of Birth:** _____ **SS#:** _____

Employer: _____ **Occupation:** _____ **Status:** Married / Single

Communication Preference: Email / Text / Phone / Mail **Preferred Language:** _____

Ethnicity: Caucasian / Hispanic or Latino / Other **How did you hear about us?** _____

Primary Care Physician: _____

Fill out the following if you have insurance and are NOT the policy holder

Policy Holder's Full Name: _____ **SS#:** _____ **DOB:** _____

RESPONSIBLE PARTY
(If patient is under 18)

Full Name: _____ **DOB:** _____

SS#: _____ **Relationship to Patient:** _____

AGREE TO TREATMENT AND ACKNOWLEDGEMENT of PAYMENT POLICY

Examination fee is due at the time of service. Any co-payments and deductibles as well as fees for non-covered tests or materials are due at the time of service, If we are a provider of your insurance and you have coverage for services or materials, we will submit claims for you. Because of the variety of insurance carriers we submit claims to, and the uniqueness of individual policies, we cannot know the extent of coverage you may have. Your insurance may not provide coverage for some materials and/or services. After 30 days we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a $30 service fee. By signing below I agree to treatment and am aware that if my account is not paid within 30 days of the date of service it may be sent to collections, I assume all legal fees and service charges incurred if collection action must be taken. ALL sales are final and no refunds are given for professional fees, glasses or contact lenses for any reason. I have read and agree to the above statements.

X_____

Signature of patient or Guarantor **Relationship *(if not patient)*** **Date**

---

* * * * * * * * * ***THIS SECTION FOR OFFICE USE ONLY*** * * * * * * * * *

Dr. TILLEY **Dr. NGUYEN** **Dr. WHITEHEAD**

PP NP CL Patient ID_____ **Last Exam**_____

Do You Wear or Have You Worn:

(Please check-mark all that apply)

○ Eyeglasses ○ Computer Glasses ○ Sunglasses ○ Contacts

Are you interested in Contacts? Yes / No **Are you interested in LASIK?** Yes / No

MEDICAL HISTORY

(Please check-mark ALL that apply AND list the approximate DATE of diagnosis)

- ○ Anxiety- (DATE:_____)
- ○ Arthritis- (DATE:_____)
- ○ Asthma- (DATE:_____)
- ○ Atrial Fibrillation- (DATE:_____)
- ○ Cancer- (TYPE:_____)(DATE:_____)
- ○ COPD- (DATE:_____)
- ○ Coronary Artery Dis.- (DATE:_____)
- ○ Depression- (DATE:_____)
- ○ Diabetes- (DATE:_____TYPE:___A1C:___)
- ○ GERD- (DATE:_____)
- ○ Hearing Loss- (DATE:_____)
- ○ Hepatitis- (DATE:_____TYPE:____)
- ○ High Blood Pressure- (DATE:_____)
- ○ HIV/AIDS- (DATE:_____)
- ○ High Cholesterol- (DATE:_____)
- ○ Pregnant- (DUE DATE:_____)
- ○ Thyroid Disease- (DATE:_____)
- ○ Seizures- (DATE:_____)
- ○ Stroke- (DATE:_____)
- ○ OTHER: _____

SURGICAL HISTORY

(List ALL Medical & Ocular procedures and DATES)

_____ _____ _____

_____ _____ _____

_____ _____ _____

OCULAR HISTORY

(Please check-mark ALL that apply AND list the DATE of diagnosis)

- ○ Cataract- (DATE:_____)
- ○ Diabetic Retinopathy- (DATE:_____)
- ○ Dry Eyes- (DATE:_____)
- ○ Glaucoma- (DATE:_____)
- ○ Macular Degeneration. -(DATE:_____)
- ○ Retinal Tear- (DATE:_____)
- ○ Strabismus/Lazy Eye- (DATE:_____)
- ○ Floaters- (DATE:_____)
- ○ OTHER:_____

MEDICATIONS

(List ALL medications and DOSAGES, including OTC and eye drops)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

(List *ALL* medication and non-medication allergies AND their reaction)

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Tobacco

- ○ Never Smoker
- ○ Current Smoker
- ○ Former Smoker

Alcohol

- ○ No Alcohol
- ○ Less than 1 drink per day
- ○ 1-2 drinks per day
- ○ 3 or more drinks per day

Current EYE Symptoms

(check-mark all circles that apply)

- ○ Blurry Vision
- ○ Irritation
- ○ Light Sensitivity
- ○ Burning
- ○ Discharge
- ○ Dryness
- ○ Pain
- ○ Tearing/Watering
- ○ Redness
- ○ Headache
- ○ OTHER:_____

FAMILY HISTORY

(Please check-mark all that apply AND list relationship to you: e.g. Mom, Dad, Sister, Brother, etc...)

- ○ Glaucoma: _____
- ○ Macular Degeneration: _____
- ○ Diabetes: _____
- ○ Rheumatoid Arthritis: _____

Tilley Eye Care Centers, LLC dba Vision Source Kerrville

708 Hill Country Dr., Suite 100

Kerrville, TX 78028

Acknowledgement of Notice of Privacy Practices

- The law requires that Vision Source makes every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

SELECT ONE CHOICE BELOW

____ I was given the opportunity to read, have read or had explained to me Vision Source's Notice of Privacy Practice prior to any services offered.

____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

- I authorize Vision Source to release my personal health information to the following individual(s)_____
  _____
- Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy. Vision Source also offers you access to your medical records and prescriptions through your secure patient portal.

SELECT ONE CHOICE BELOW

____ I authorize the use of standard email to communicate with me as well as send my glasses/contact prescription when I request it, in spite of the known risk.

____ I authorize the use of standard email to communicate with me in spite of the known risk involved.

____ I do not authorize the use of standard email to communicate with me. By selecting this option, I realize that I will not have access to my patient portal.

EMAIL ADDRESS: _____

Acknowledgement of Payment Policy

Examination fees, co-payments, and non-covered tests or materials are due at the time of service. If we are a provider for your insurance and you have coverage for services and/or materials, we will submit claim(s) for you. You agree to authorize the release of any medical information necessary to process claims and authorize payment of benefits to Vision Source for services and/or materials as outlined on medical/vision claims submitted by our office. If there is incorrect or insufficient information provided by the patient or guardian, you will be billed our usual and customary fees and provided with a receipt so that you may file the claim yourself. Our office will send one courtesy invoice and payment is expected within 30 days of receipt. If any additional invoices must be sent due to lack of payment, your account will be assessed a $10 administrative fee per invoice.. Any account that has not been paid within 90 days from the original invoice date may be turned over to a third-party collection service. You assume all legal fees and service charges incurred if collection action must be taken. Returned checks will be charged a $30 service fee.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGINING IT VOLUNTARILY.

If you are signing as a personal representative of the patient, please indicate your relationship. **If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.**

_____ _____

Patient/Representative Signature Printed Name of Patient

_____ _____ _____

Print Name of Representative Relationship to Patient DATE

Questionnaire

*(*Please Complete*)*

Do your eyes...	**No Problems/Tolerable (0)**	**Mildly (1)**	**Moderately (2)**	**Severely (3)**
feel dry, gritty or scratchy?	☐	☐	☐	☐
water excessively?	☐	☐	☐	☐

Do you use eye drops for lubrication? ☐ **YES (1)** ☐ **NO**

Do you have difficulty seeing at night or in low lit environments? ☐ **YES** ☐ **NO**

Optomap

*(*Please read for details*)*

The Optomap is an ultra-wide digital retinal imaging device. Images can be used for diagnosing, documenting and comparing the health of your retina each year. While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough screening of the retina is critical to verify that your eyes are healthy. This can offer early detection of common diseases, such as glaucoma, diabetes, macular degeneration, and even cancer. Most retinal conditions and other diseases can be treated successfully with early detection.

Please Initial your selection

_____ **YES**, I would like to take advantage of the Optomap for ***$39.***

_____ **NO**, I decline the Optomap.

Patient Signature:_____ **Date:** _____

If you have any additional questions or would like further explanation, please ask your technician!