Turn Over

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

Last Name: _____ First Name: _____ MI: ____ Nickname: _____ 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: _____

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 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

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* * * * * * * * * *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- DATE _____ TYPE _____
❑ 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: _____

OCULAR SURGICAL HISTORY

(Ocular procedures and DATES)

_____ _____ _____
_____ _____ _____
_____ _____ _____

OCULAR HISTORY

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

❑ Cataracts- 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 vitamins and eye drops)

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES

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

_____ _____ _____
_____ _____ _____

SOCIAL HISTORY

❑ Never Smoker ❑ Current Smoker ❑ Former Smoker ❑ Smokeless Tobacco

FAMILY HISTORY

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

❑ Glaucoma: _____
❑ Macular Degeneration: _____
❑ Diabetes: _____

CURRENT EYE SYMPTOMS

(check-mark all circles that apply)

❑ Blurry Vision ❑ Burning ❑ Pain ❑ Headache
❑ Light Sensitivity ❑ Discharge ❑ Tearing/Watering ❑ Other:_____
❑ Irritation ❑ Dryness ❑ Redness ❑ Other:_____

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:

Initial *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)

_____

_____

ACKNOWLEDGEMENT OF THE USE OF STANDARD EMAIL

- 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.

Initial *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

_____ _____ _____

Printed Name of Representative Relationship to Patient DATE