Welcome to Tippett EyeCare!

Whom may we thank for your referral? _____

First Name: _____ MI:_____ Last Name:_____

DOB: _____ SSN:_____

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

Home phone:_____ Cell phone:_____ Work phone:_____

Email:_____

Emergency Contact:_____ Phone:_____

Responsible Party/Primary Insured Information

First Name: _____ MI:_____ Last Name:_____

DOB: _____ SSN:_____ Relation to Patient:_____

Employer:_____ Insurance Company:_____ ID#:_____

Phone number:_____

Please list any additional insurance you have below:

Additional Medical Insurance:_____ ID#:_____

Primary Insured:_____ DOB:_____ SSN:_____

Routine Vision Insurance:_____ ID#:_____

Primary Insured:_____ DOB:_____ SSN:_____

Assignment and Release

Insurance quotes received from our office are an estimate only. By signing below you acknowledge that your policy is an agreement between you and your insurance company and not with your office. You also agree to release assignment to Tippett EyeCare for payment. Be assured we will make every effort to collect from the insurance company. If after 90 days your insurance company has not paid for your claim, we retain the right to ask you to pay this claim and for you to contact the insurance company for reimbursement. All claims that are not paid within 90 days of your first billing cycle can be sent to a Collections Agency. The Collections Agency will add a collections fee (50% of the account balance) that you agree you will pay in addition to original account balances, attorney fees, court costs, and any other fees to collect payment.

A returned check fee of $35.00 will be added to the cost of returned checks. We ask that any NSF is to be made good within 10 business days. After 10 business days, we retain the right to take legal action.

Most eyeglass lenses are specially manufactured to your specific prescription. Once the lenses have been ordered from the lab, a cancellation or refund cannot be offered.

You authorize this office to release any and all information required to process insurance claims and to collect on your behalf.

You acknowledge that you have been given the opportunity to read the HIPPA agreement on file at Tippett EyeCare, PC.

My signature will serve as signature on file.

Patient signature (or guardian):_____ Date:_____

Print name:_____

Consent to Treat

All minors must be accompanied by a parent or guardian to receive services

Contact Lens Evaluation

A contact lens exam will require an evaluation and additional measurements taken by our doctors and staff. The contact lens evaluation is a separate fee that is required to be paid on the date of service. Some insurances will cover this service and we will gladly file this on your behalf. We require that most contact lens evaluations are finalized within 45 days from the contact lens evaluation bill date. After 45 days there will be a charge for an office visit, refraction and re-evaluation. Contact lens evaluations start at $79.00 and range up to $125.00 depending on what lens the doctor feels is best for your visual needs.

Medical vs. Routine

Routine vision plans are for healthy eyes only. We may not be able to file your routine vision plan if there is a medical condition that needs to be addressed. We may also require additional tests in order for our doctors to be able to diagnose and treat ocular concerns. We will file claims to your insurance upon receipt of your most current medical insurance card. Most tests are covered under your medical plan. Although these tests aid our doctors in diagnosis and treatment, there are some tests that may be considered experimental by your insurance, and therefore will not be covered. Many insurance plans also have deductibles, co-insurance and co-pays that are required at the time of services. In all cases you acknowledge with your signature that you are responsible for the payment of these services.

We offer many methods of payment; Cash, Check, Debit, Credit Card and also Care Credit.

Your payment is expected on the date of service.

Patient Name (please print):_____

Patient Signature:_____

Date:_____

Staff Initials:_____

Authorization for Additional Testing

As part of a comprehensive Eye Examination, our office utilizes advanced technologies to create a photographic record of your retina. We consider this testing an option a part of our routine examination. Your insurance **will not** cover the cost associated, therefore your financial billing statement will reflect the charge of the test(s) you choose.

How does this test benefit you?

-They provide your doctor the best possible information to diagnose, manage, and treat eye disease.

-They are permanent, detailed records of your eye health and general health.

-They can be transferred to other doctors almost instantly.

If you have medical complaints, are Diabetic or seeing Flashes or Floaters you will be dialated. These packages are for healthy eyes only.*

I have read and understand the importance of this testing.

Please check the box if you wish to have this test done:

Augusta ☐ CLARUS $29.00

Grovetown ☐ OPTOS $29.00 ☐ HRT $29.00 ☐ Wellness Package $47.00 (OPTOS/HRT)

Privacy of your Medical information and Medical Billing

By signing below, I acknowledge that I have been given the opportunity to review electronically (or in print) the Privacy Policy and the Insurance and Billling Practices in effect for Tippett Eye Care. Further, I have been informed that I may request a copy of these policies at any time.

I understand that, under the provisions of the privacy policy, my health care information may not be shared with anyone except as outlined by the policy. However, I wish to grant the following individuals unrestricted access to my information.

1._____

2._____

3._____

Signature or Signature of Parent/Guardian Date(dd/mm/yy)

_____ _____

Patient Medical History Form

NAME:_____ DOB:_____ DATE:_____

Please mark any of the following eye symptoms or conditions you are currently experiencing:

Cataracts_____
Glaucoma_____
Macular degeneration_____
Retinal disease_____
Cornea disease_____
Light sensitivity_____
Night glare_____
Color difficulty_____
Depth perception problems_____
Night vision problems_____
Flashing lights_____
Floating spots_____
Red eye_____
Painful eyes_____
Achy eyes_____
Itchy eyes_____
Burning eyes_____
Dry eyes_____
Watery eyes_____
Discharge_____
Blurred vision_____
Distorted vision_____
Excessive Squinting_____
Double vision_____
Dizziness_____
Crossed eyes_____
Other:
_____
_____
_____

Please mark any of the following conditions you are currently experiencing:

Constitution
Developmental disability___
Cancer___
Fatigue syndrome___

Cardiovascular
Hypertension___
Stroke/CVA___
Heart disease___
Vascular disease___
Congestive heart failure___

Muscular/Skeletal
Osteoarthritis___
Arthritis___
Fibromyalgia___
Muscular dystrophy___
Ankylosing spondylitis___
Osteoporosis___
Gout___

ENT
Hearing loss___
Sinusitis___
Dry mouth___
Laryngitis___

Respiratory
Asthma___
Bronchitis___
Emphysema___
Sleep apnea___

Integumentary
Eczema___
Rosacea___
Psoriasis___
Cold sores___
Shingles___

Neurological
Multiple sclerosis___
Cerebral Palsy___
Tumor___
Migraine___
Headache___

Genitourinary
Kidney diease___
Prostate disease___
STD___
Pregnant___
Nursing___

Hemo/Lymph
Anemia___
Blood loss___
High cholesterol___

Psychiatric
Dyslexia___
Depression___
Attention deficit___
Anxiety disorder___
Bipolar disorder___
Schizophrenia___

Gastrointestinal
Chron's___
Colitis___
Ulcer___
Acid reflux___
Celiac disease___

Endocrine
Type 1 Diabetes___
Type 2 Diabetes___
Thyroid dysfunction___
Hormone dysfunction___

Allergy/Immune
Rheumatoid arthritis___
Lupus___
Sjogren's Syndrome___
Drug/Environ Allergy___

Are you currently taking any medications or supplements? Yes___ No___

If yes, please list below:

_____
_____
_____

Please list any drug or environmental allergies below:

_____
_____

Do you have a latex sensitivity? Yes___ No___
Do you use (check if yes): Alcohol___ Tobacco___
Have you ever been a smoker? Yes___ No___

Do you wear glasses? Yes___ No___ ***Do you feel there has been a change in your prescription?*** Yes___ No___

Do you wear contacts? Yes___ No___ ***What type?*** Soft___ Gas perm___ Scleral___ ***What brand?*** _____

Please indicate which immediate family member has/had any of the following conditions:

(M=Mother, F=Father, S=Sibling, GM=grandmother, GF=grandfather)

Blindness___
Hypertension___
High cholesterol___
Cataracts___
Macular degeneration___
Thyroid disorder___
Glaucoma___
Cancer___

Patient signature (or guardian):_____ ***Date:***_____