total eye care, p.a.
memphis

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6060 primacy pkwy., suite 200 • memphis, tennessee 38119
(p) 901.761.4620 • (f) 901.761.3072 • *totaleyecarememphis.com*

Welcome to Total Eye Care, P.A.

Your appointment at Total Eye Care, P.A. has been scheduled for _____ at _____ o'clock.

In order to shorten your wait time before your examination, **please complete the enclosed forms and bring them with you for your appointment.**

- Patient Registration Form
- Patient Responsibility and Assignment Form
- Patient Medical History Questionnaire

Please remember to bring the following:

- A list of your current medications
- Your current eyeglasses
- A referral if required by your insurance company (Please note that it is your responsibility to obtain the referral if one is required).

Financial Responsibility

You are responsible for any unmet deductibles and/or co-payments at the time of your visit. If you have any questions, please do not hesitate to call and speak with one of our caring team members. We look forward to seeing you and providing you with the quality eye care you deserve.

Sincerely,

The Doctors and Staff of Total Eye Care, P.A.

Directions to Total Eye Care, P.A.

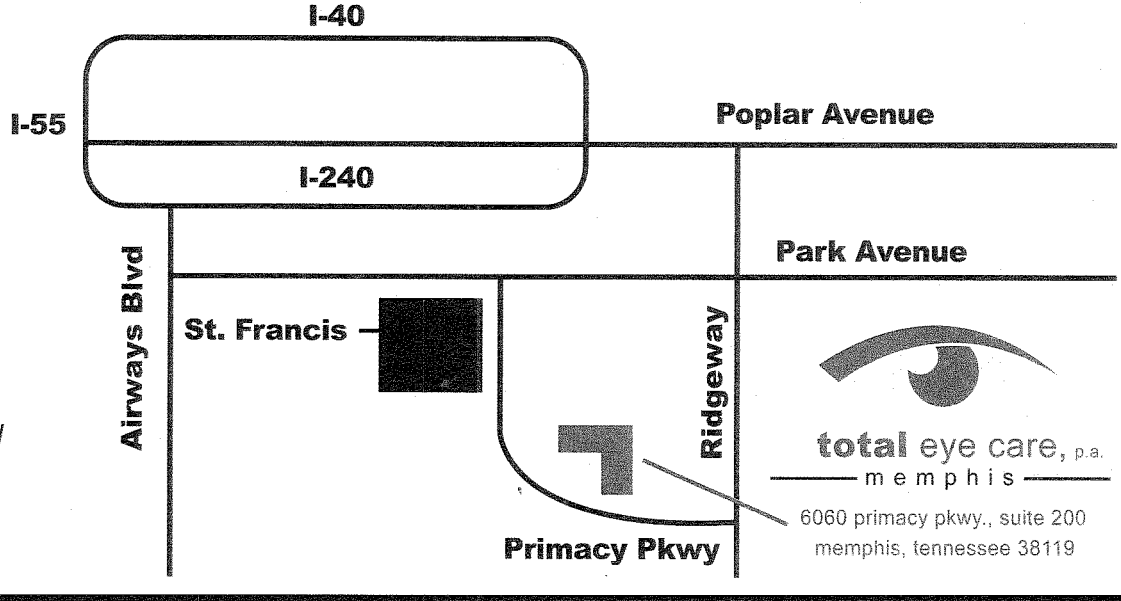
Take 1-240 to the Poplar Exit and take Poplar East.

Turn Right on Ridgeway and Right on Park.

Primacy Parkway is the first left.

We are the second building on the left past La Quinta Inn Hotel.

For further directions, please call our office at 901.761.4620.



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PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

HOME ADDRESS	HOME PHONE	BIRTH DATE
	CELL PHONE	SOCIAL SECURITY #

GENDER

☐ Male ☐ Female

MARITAL STATUS

☐ Single ☐ Widowed
☐ Married ☐ Divorced

RACE

☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Caucasion or White
☐ Native Hawaiian or Pacific Islander ☐ Other

If "Other," please specify: _____

ETHNICITY	PATIENT EMPLOYER	WORK ADDRESS
☐ Hispanic or Latino		
☐ Not Hispanic or Latino	OCCUPATION	
☐ Unknown		

WORK PHONE	EMAIL ADDRESS

SPOUSE NAME	SPOUSE BIRTH DATE	SPOUSE SOCIAL SECURITY #

SPOUSE EMPLOYER	SPOUSE WORK PHONE	SPOUSE WORK ADDRESS

PERSON WHO REFERRED YOU TO THIS OFFICE	

EMERGENCY CONTACT	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT ADDRESS
RELATIONSHIP	ALT PHONE	

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PATIENT INFORMATION

PERSON RESPONSIBLE FOR CHARGES *(If patient is responsible, mark "Same as previously stated")*		
☐ Same as previously stated		
LAST NAME: _____ FIRST NAME: _____ MI: _____		
ADDRESS	**RELATIONSHIP**	**HOME PHONE**
	SOCIAL SECURITY #	**CELL PHONE**
EMPLOYER		**WORK PHONE**

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	POLICY #
INSURED'S NAME	**GROUP #**

SECONDARY INSURANCE COMPANY	POLICY #
INSURED'S NAME	**GROUP #**

I authorize the release of any medical information necessary to process this claim.

I authorize payment of medical benefits to undersigned physician or supplier for service described.

Signature of Insured or Authorized Person: _____ **Date:** _____

Our office will verify your insurance coverage before you are seen. This is for your benefit. We will work with the insurance company for payment of your account; however, ultimately it is your responsibility.

Signature of Patient: _____ **Date:** _____

Parent/Guardian Signature if patient is a minor: _____ **Date:** _____

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PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

AGE: _____ PRIMARY CARE PHYSICIAN: _____

ALLERGIES TO MEDICATIONS: _____

LIST ALL CURRENT MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please indicate if you have any of the following conditions:

	NO	YES			NO	YES	
High Blood Pressure	☐	☐	_____	Stomach/Gastrointestinal	☐	☐	_____
Diabetes	☐	☐	_____	Liver Disease	☐	☐	_____
Asthma/Emphysema	☐	☐	_____	Bladder/Prostate Problems	☐	☐	_____
Skin Diseases	☐	☐	_____	Kidney Disease	☐	☐	_____
Heart Condition	☐	☐	_____	Cancer	☐	☐	_____
Thyroid Disease	☐	☐	_____	Stroke/Neurological Disease	☐	☐	_____
Lupus	☐	☐	_____	Psychiatric Problems	☐	☐	_____
Arthritis	☐	☐	_____	AIDS/HIV Positive	☐	☐	_____
Other _____				Pregnant/Nursing	☐	☐	_____

Surgical Procedures: _____

Social History:	NO	YES	
Tobacco	☐	☐	How many a day? _____
Alcohol	☐	☐	How much per day/week? _____
Exercise	☐	☐	How often? _____

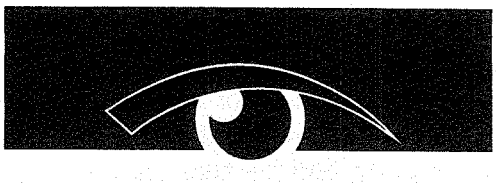
Previous Eye History:

	NO	YES					
Do you wear glasses?	☐	☐	How old is the prescription? _____				
Do you wear contacts?	☐	☐	Type? Since when? _____				
Eye Injuries	☐	☐	_____	Glaucoma	NO	YES	_____
Cornea Problems	☐	☐	_____	Detached Retina	☐	☐	_____
Cataracts	☐	☐	_____	Macular Degeneration	☐	☐	_____
Crossed/Lazy Eye	☐	☐	_____	Other: _____			
Eye Surgery	☐	☐	_____				

Family History of Eye Problems:

None	☐			
Cataract	☐	_____	Glaucoma	☐ _____
Retinal Problems	☐	_____	Other	☐ _____

PATIENT SIGNATURE: _____ DATE: _____



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PATIENT FINANCIAL POLICY

Total Eye Care, P.A., is a participating provider with many managed health care insurers to accommodate the needs of our patients.

We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of the relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

Co-Pays
The patient is expected to present an insurance card at each visit. All co-payments, past due balances and any additional costs not covered by your insurance company are due at time of appointment. We accept cash, check, or credit cards.

Insurance Claims
Insurance is a contract between you and your insurance company. With each insurance program, there are many individual requirements for these plans and the same insurance type may have different benefits based upon the employer group or individual policy.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including by not limited to those charges about the usual and customary allowance. If we are out of network for your insurance company and your insurance pays directly to you, you are responsible for payment and agree to forward the payment to us immediately.

Major Participating Insurance Plans
The following is a partial list of the health plans for which Total Eye Care, P.A. is a participating provider. If you have any questions regarding our participation status with your insurance plan, please check directly with your insurance.

Aetna
Baptist Health Service
Block Vision
Blue Cross
Cigna
Comp Benefits
Coventry
GEHA
Healthspring
Humana
Medicare
Mailhandlers
PHCS
Railroad Medicare
Superior Vision
Tricare
United Healthcare
VSP
Windsor

Referral and Prior Authorizations
If your insurance company requires a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain the referral and/or prior authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Upon scheduling your appointment, you will be advised of an estimate of the amount needed to pay for your services and you will be asked to make payment arrangements for any remaining balance. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Returned Checks
The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements, If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event your account is turned over to a collection agency, a charge equal to thirty-three percent (33%) of the outstanding account balance will be added to your account to cover the additional collection costs and fees.

The financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at (901) 761-4620 and ask to speak to a billing representative.

I accept and understand the Total Eye Care, P.A., Financial Policy.

_____ _____

Patient Signature (Parent or Guardian, IF Minor) Date

_____

Printed Name of Signer

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS: The attached Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Please sign below stating that you have received a copy of the Notice of Privacy Practices, and return this cover page to the staff person who gave it to you.

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR RECEIPT OF THE ATTACHED NOTICE OF PRIVACY PRACTICES:

I (*Patient Name*), _____, do hereby acknowledge receipt of Total Eye Care, P.A.'s Notice of Privacy Practices on (*date*) _____.

_____ _____

Patient name (please print) *Signature of patient or personal representative*

**If personal representative, please list relationship:* _____

(Office Use Only)

Total Eye Care, P.A. staff person's name: _____

Patient Medical Record Number: _____ Date: _____

☐ Check if applicable. Patient did not acknowledge receipt of Notice of Privacy Practices (explain):

_____

_____