WELCOME TO BLOUNT COUNTY EYE CENTER

ID #: _____

DATE: ___/___/___

WHO ARE YOU?

Name _____ DOB ___/___/___ Age _____

Name You Go By _____ SSN _____

ABOUT YOU

Address _____ City _____

State _____ Zip _____ Email _____

Phone (type) _____ Alternate Phone (type) _____

I am Currently:

☐ Employed ☐ Student ☐ Retired ☐ Disabled ☐ Not Employed ☐ Other _____

Occupation _____ Employer/School _____

Race (Optional):

☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Hispanic
☐ White (Hispanic) ☐ White (Not Hispanic or Latino) ☐ African American
☐ Other Pacific Islander: _____ ☐ Other: _____

How did you hear about us? ☐ Insurance ☐ Mailer ☐ Referred by Family or Friend
☐ Community Event ☐ Other: _____

ABOUT INSURANCE

Primary Medical Insurance _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ D.O.B. _____

Secondary Medical Insurance _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ D.O.B. _____

Vision Benefit Plan _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ D.O.B. _____

CONTACTING YOU

Please select the way(s) in which you would like Blount County Eye Center to attempt to contact you for appointment reminders, questions on your account, eye wear job status, etc.

☐ Phone ☐ Email ☐ Mail ☐ Text

TODAY'S VISIT

Accompanied Today By: _____ Relationship to Patient: _____

Last Eye Exam: _____ Where?: _____

Were you referred to BCEC today by another physician? ☐ No ☐ Yes: _____

Briefly describe why you are seeking an eye exam today: _____

MEDICATION

Please list all medications you are currently taking including all eye drops. Include any over-the-counter medications and / or supplements. Please indicate if you've provided a current list for today's exam.

Medication Allergies: _____

Other Allergies: _____

VITALS

Height: _____ feet and _____ inches. Weight: _____ pounds.

SOCIAL HISTORY

Smoking History: ☐ No History of Smoking

☐ Current Smoker. Amount/Day: _____ ☐ Former Smoker. Amount/Day: _____

Drug Use: ☐ No ☐ Yes: _____

Alcohol Use: ☐ No ☐ Yes. Frequency: _____

FAMILY MEDICAL HISTORY

Does a member of your family have, or have they had, any of the following conditions? Please indicate who next to the appropriate condition.

☐ Cancer _____ ☐ Diabetes _____ ☐ Cataracts _____
☐ Glaucoma _____ ☐ Macular Degeneration _____
☐ High Blood Pressure _____ ☐ Other _____

REVIEW OF SYSTEMS

Check any of the following conditions that apply to you:

CONSTITUTION
- ☐ Cancer
- ☐ Headache
- ☐ Developmental Disabilities

EAR / NOSE / THROAT
- ☐ Sinus Condition
- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Laryngitis

NEUROLOGICAL
- ☐ Migraines
- ☐ Epilepsy
- ☐ Tumor
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Autism Spectrum Disorder

PSYCHOLOGICAL
- ☐ ADD / ADHD
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Muscular Dystrophy
- ☐ Gout

RESPIRATORY
- ☐ Bronchitis
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Emphysema
- ☐ Cigarette Smoker
- ☐ Chronic Obstruction

GASTROINTESTINAL
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Celiac Disease
- ☐ Acid Reflux
- ☐ Ulcer

GASTROURINARY
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD
- ☐ Benign Prostate
- ☐ Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

INTEGUMENTARY
- ☐ Rosacea
- ☐ Shingles
- ☐ Psoriasis
- ☐ Eczema
- ☐ Cold Sores

ENDOCRINOLOGY
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Condition
- ☐ Hormone Disorder

BLOOD DISORDER
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Larger Volume Blood Loss
- ☐ Ulcer

IMMUNOLOGICAL
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Drug Allergies
- ☐ Environmental Allergies

Primary Care Physician: _____ Do You Need One? ☐ Yes ☐ No

Other Medical Conditions: _____

_____

Surgical History: _____

_____

CONSENT FOR MESSAGES

I give permission to the physicians and their staff at BCEC to (initial chosen options):

TEXT AND VOICE MESSAGES FOR GENERAL HEALTHCARE INFORMATION:

_____ Leave text and voice messages at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my healthcare when I am not available.

_____ Leave voice messages regarding my health information including results and diagnostic information, payments of balance, care plans, referrals, when I am not available at the following number.

Cell _____ Phone _____

SHARING OF YOUR HEALTH INFORMATION AND RESULTS

_____ I give permission to the physicians and staff at BCEC to share my health information including results, diagnoses, and appointment information with the following person(s).

The persons you list will also be permitted to pick up prescriptions on your behalf if you are unable.

Name	Relation	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

BCEC
BLOUNT COUNTY EYE CENTER

If all of the information listed is accurate, please sign below.
Thank you for choosing BCEC!

Patient Signature: _____ Date: ___/___/___

Parent Signature: _____ Date: ___/___/___

BCEC
BLOUNT COUNTY EYE CENTER

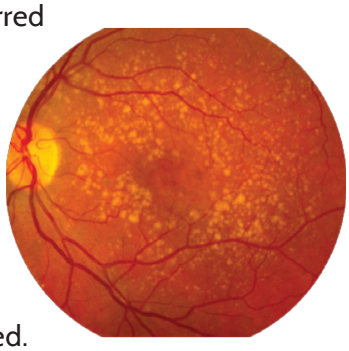
RETINAL HEALTH EVALUATION

One of the most important parts of today's comprehensive eye exam is the examination of the inside part of your eye, the retina. A healthy retina is critical to your vision, and needs to be examined for such conditions as macular degeneration, glaucoma, retinal holes, retinal detachments and complications from diabetes, high blood pressure and high cholesterol.

THERE ARE TWO METHODS FOR THE BCEC EYE DOCTORS TO PROPERLY EVALUATE YOUR RETINA

DILATION OF THE PUPIL

This traditional procedure allows your eye doctor a 3D evaluation of the retina using eye drops to enlarge and stabilize your pupils. They then use a high-powered microscope and magnifying lenses to view inside your eyes. The drops used will cause your vision to be blurred and your eyes to be sensitive to lights/sunlight for 2-4 hours in most cases. Patients with diabetes or retinal symptoms should be dilated on a yearly basis.



HIGH-DEFINITION RETINAL IMAGING

This technology offers an ultra-wide view of the retina and allows your eye doctor to instantly evaluate your retinal health. In many cases, in otherwise healthy patients, dilation is not required if photos are evaluated. These digital images can be stored for future use in detection of subtle retinal changes. They can also be sent to other physicians in the event that you ever require co-managed care.

THE MOST THOROUGH RETINAL EVALUATION WOULD BE TO HAVE BOTH PROCEDURES PERFORMED AS THEY COMPLEMENT EACH OTHER IN DETECTING SIGHT THREATENING CONDITIONS.

THE EYE DOCTORS AT BCEC HIGHLY RECOMMEND AT LEAST ONE OF THESE TESTS TO COMPLETE YOUR COMPREHENSIVE EYE EXAM.

During my comprehensive eye exam today, I would like:

☐ **Dilation** (Included in your exam)

☐ **High-Definition Retinal Imaging** (Additional $25 charge, not covered by most insurances)

☐ **Neither Procedure.** By choosing this option you agree to the following: I have chosen to have neither test performed against the recommendation of the BCEC eye doctors. I will not hold the physicians or practice responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through retinal imaging or dilation.

Signature: _____ Date: ___/___/___

BCEC
BLOUNT COUNTY EYE CENTER

PRACTICE POLICY AGREEMENT

Name: _____

ID #: _____ D.O.B. ___/___/___

AUTHORIZATION FOR INSURANCE PAYMENTS

Initials: _____

We request your signature on file in the event the office files insurance for you. This clause applies to all insurance and vision benefit carriers. This signature will serve as authorization for the lifetime of the patient for which it is on file. I request that payment of authorized carrier of Medicare benefits be made either to me or on my behalf to Blount County Eye Center, PLLC for any services furnished me by this/these doctors. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Initials: _____

I have had the opportunity to receive a copy of this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

INSURANCE RELATIONSHIP AND PATIENT RESPONSIBILITIES

Initials: _____

BCEC, PLLC has contractual agreements in place with insurance companies and/or vision benefit plans which state BCEC will provide covered services and bill for those services appropriately. The patient has a contractual agreement in place with their insurance provider and/or vision benefit provider which entitles them to some extent of coverage and/or benefits with the use of their plan. BCEC, PLLC does not work for the patient's insurance company and/or vision benefit plan. As a courtesy to their patients, BCEC files appropriate claims to insurance companies and/or vision benefit providers for services and materials provided so that debts incurred to BCEC on the patient's behalf may be met. However, the patient is ultimately responsible for meeting all of their debts incurred with the practice. When a patient disputes an action by an insurance company and/or vision benefit plan, it is ultimately the responsibility of the patient to work with that company resolve the issue(s).

Both vision benefit and medical insurances cannot be billed on the same date of service without risk of denial and balances being transferred to patients. Our physicians will address the most pressing eye health issue and bill appropriately in their professional judgement, but this may require multiple visits to completely care for your eye health care needs. You will be informed when this is the case whenever possible.

ACCOUNT PAYMENT & RESPONSIBILITIES

Initials: _____

I understand that all fees for products and/or services not covered by insurance and co-pays are due at the time of service. I understand that any balances not covered by my insurance or vision benefit plan will be my responsibility. Outstanding balances will be sent in statement form via USPS. Delinquent accounts will be turned over to collections when necessary, and I will be responsible for both my account balances as well as any fees incurred on behalf of BCEC, PLLC from the collections agency. Orders for eyewear products cannot be placed until payment is made.

REFUND POLICIES

Initials: _____

Professional fees for exams and/or professional services cannot be refunded once performed. Product refunds must be processed and will be issued by check. In the event of returned eyewear, there may be a frame and/or lens restocking and return fee. By signing below, I acknowledge understanding and acceptance of these policies.

EYEWEAR PRESCRIPTION POLICIES

Initials: _____

Eyewear prescriptions are valid for defined period as dictated by your eye doctor. BCEC, PLLC will not fill a prescription that has expired. An eyewear prescription is not legally valid until your eye doctor has deemed it finalized and signed off on that prescription as being such. Failure to complete a fitting with your doctor will result in an unfinalized prescription that is not valid to be filled, so it is important that you comply with your doctor's orders. BCEC, PLLC owns all eyewear prescriptions until payment has been received in full for that prescription. Patients are welcome to a copy of their eyewear prescriptions at any time following receipt of payment and until a date on which the prescription expires.

PRACTICE CULTURE AND PATIENT RESPONSIBILITIES

Initials: _____

Blount County Eye Center, PLLC has built a proud tradition of inclusion and respect that we will always adhere to. We reserve the right to refuse service to anyone who we believe violates this, and we reserve the right to dismiss any patient who behaves in a manner that violates our cultural standards of behavior. We ask that when disputes arise regarding your care, your eyewear or your accounts that you handle them in a manner that is respectful to our hardworking staff members and doctors. Vulgar, degrading or violent behavior and/or language will never be tolerated within our practice, and we reserve the right to prosecute violators to the fullest extent of the law when appropriate.

Please Sign Here: _____ Date: ___/___/___

Relationship to Patient if Guardian: _____