

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

Please complete all blanks

Name: First: _____ MI: _____ Last: _____

DOB: _____ Social Security #: _____ - _____ - _____

Mailing Address:

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Information:

Home Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

*Can we leave a detailed message on these numbers? Y or N (Please circle one)

Email Address: _____ Occupation: _____

*Preferred Method of contact? (Please Circle) Phone Text Email

Please Circle or Complete:

Sex: M / F **Gender Identity:** _____ **Marital Status:** Single / Married / Divorced / Widowed

Race: American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian / Other Pacific Islander / White / Other: _____ (Please Specify)

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

Emergency Contact Information: Name: _____ Phone #: _____
Relationship to Patient: _____

Insurance Information: (Please provide insurance cards to front desk)

Insurance Policy Holder Information (if other than patient):

Name: _____ Date of Birth: _____ Phone #: _____

Social Security #: _____ Relationship to Patient: _____

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

Parent or Guardian Information (if patient is younger than 18):

Name: _____ Date of Birth: _____ Phone #: _____

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

Relationship to Patient: _____

I am interested in learning about the following services/products:

Refractive Surgery Vitamins for Eye Health Cosmetic Procedures Skin Care Dry Eye

The above information is true and correct to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for West Tennessee Eye Care, P.C. to furnish medical care and treatment to myself or _____ which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at the time of treatment unless prior arrangements have been made with our office. I understand that in the event that my account is placed with a collection agency, a collection fee of up to 33.3% may be added to my account and shall become a part of the total amount due. In the event my account is placed with an attorney, I will be responsible for reasonable attorney fees and court costs. I agree, that in order for you to service my account or to collect any amounts I may owe, WTEC and your collection agencies may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. WTEC and your collection agencies may also contact me by sending text messages and/or emails, using any email address I provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize West Tennessee Eye Care, P.C. to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment or benefits to be made directly to West Tennessee Eye Care, P.C. for services provided to me or my dependents.

MEDICARE and/or MEDIGAP ONE-TIME AUTHORIZATION

I request that payment for authorized Medicare and/or Medigap benefits be made on my behalf to West Tennessee Eye Care, P.C. for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

CLAIM FILING CONSENT

I agree to give Greenway Revenue Services authorization to file insurance for medical claims on behalf of West Tennessee Eye Care, PC.

ADVANCED DIRECTIVES

I have a living will or durable power of attorney. ___Yes ___No

If you do have a durable power of attorney, please identify: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received West Tennessee Eye Care's Notice of Privacy Practices.

Name of Patient

Patient's Date of Birth

Signature of Patient/Guardian/Parent

Date

This acknowledgement page should be retained in patient's record. If acknowledgement could not be obtained for patient, the reasons must be documented.

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we still strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rest with the patient.

Our office participates with most major insurance plans, both vision and medical. We provide medical and surgical ophthalmologic care to our patients, as well as routine eye exams. Therefore, if your current insurance plan requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to being worked up by our technicians.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance, and deductibles.
- Bring all of your current insurance cards to all visits. Provide our office with current information including address, phone numbers, and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks, and most major credit cards.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you, Any payment made by check that does not clear your bank account will result in a \$25.00 fee, which will be added to your account and must be paid before the next visit

For all services rendered to minor/dependent parties, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used

Refunds:

If a requested refund is approved, then your refund will be processed to the original form of payment except cash payments. All check and cash payments will be refunded by check and mailed to the address on file. All payments by credit or debit card will be refunded the amount charged by the clinic, minus the credit card processing fee. This amount is determined by the percentage set by the POS system.

I have read and understand the above financial policy.

Printed Name of Patient

Signature of Patient/Guardian/Parent

Date

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

Vision Plans versus Medical Insurance - Explanation of Coverage

We often have patients that have both a vision plan and medical insurance. Vision plans and medical insurance are very different terms of the services they cover and it's important for our patients to understand those differences.

Vision Plans

Vision plans cover a routine comprehensive eye exam, including refraction, when the patient's only complaint is vision related (fixed by glasses or contact lenses) or when the patient has no eye complaint at all. If you have complaints or if you have known eye problems which require being followed by a doctor, your vision insurance will not cover the visit.

You would then be financially responsible for the examination if you do not want it sent to your medical insurance. Common eye complaints NOT covered by vision plans include but are not limited to: redness, tearing, itching, dryness, headache and floaters.

Medical Insurance

Your medical insurance **WILL** consider any eye exam and testing related to a non-vision (glasses or contacts) related complaint, any ongoing medical eye issue and many systemic medical symptoms and diseases which can affect the eyes. Examples include but are not limited to: headaches, high blood pressure, diabetes and thyroid issues, as well as redness, tearing, itching, dryness, headache and floaters. Your medical insurance will **NOT** cover routine vision complaints or refraction. You may elect to pay for these procedures, which range from 40-95 dollars.

For the convenience of our patients, West Tennessee Eye Care, PC dba Toyos Clinic participates with most every major vision plan and medical insurance carrier. As required, we will file those claims for you. In the event that we do not participate with your medical insurance or vision plan, we will provide you with an itemized receipt so that you may file with your insurance carrier for any out-of-network benefits to which you may be entitled. If you have any questions, please let us know.

I acknowledge understanding of the information above and authorize West Tennessee Eye Care, PC dba Toyos Clinic to file claim(s) with my insurance(s) as appropriate.

Printed Name of Patient

Signature of Patient/Guardian/Parent

Date

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

No-show/late cancellation policy:

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling our office, responding to your confirmation message, or emailing kbusby@toyosclinic.com.

If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. **No-show appointments may be subject to a \$25 fee.** No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

If our office must cancel your appointment with less than 24 hours notice, you may choose to meet with a different provider (if available) on the same day, to reschedule, or to cancel. In these circumstances, we will not charge you a cancellation fee.

If you have questions about our cancellation policy, or you're experiencing an emergency, please call 888-315-3937 or email the front office manager at kbusby@toyosclinic.com.

Printed Name of Patient

Signature of Patient/Guardian/Parent

Date

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

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Toyos Clinic - Medical History Questionnaire

Name: _____ Age/Race/Gender: _____ Date: _____

Other Doctors participating in your care (Name/Specialty/Location): _____

Reason for today's exam: _____

Family History: Do your parents, siblings, or children have any of the following? **Please circle** and indicate the relationship.

Diabetes High Blood Pressure Cancer Retinal Detachment Glaucoma Blindness

Other Details: _____

Personal History: Are you currently taking medication for or have you ever been diagnosed or treated for the following conditions?

AUTOIMMUNE

- Lupus
- Psoriasis
- Rheumatoid Arthritis
- Sjögren's Syndrome
- Other: _____

CARDIOVASCULAR

- Angina
- Congestive Heart Failure
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Irregular Heart Beat
- Murmur
- Pacemaker or Bypass
- Stroke
- Valve Replacement
- Vascular Disease

CONSTITUTIONAL

- Cancer, Type: _____
- Fever
- Sleep Disorder, Type: _____
- Weight Loss/Gain

ENDOCRINE

- Diabetes: Insulin Dependent (Circle) Type 1 / Type 2
- Diabetes: Non-Insulin Dependent
- Pre-Diabetic
- Thyroid Abnormality
- Thyroid Disease

EARS, NOSE, MOUTH, THROAT

- Chronic Cough
- Dry Throat/Mouth
- Seasonal Allergies
- Sinus Congestion

GENITOURINARY

- Kidney Stones
- Polycystic Ovary Syndrome (PCOS)
- Prostate Disorder
- STD, Type: _____

GASTROINTESTINAL

- Constipation
- Diarrhea
- Gerd
- Reflux

HEMATOLOGICAL/LYMPHATIC

- Anemia
- Bleeding Problems
- Hepatitis B/C
- HIV/AIDS
- Tuberculosis

INTEGUMENTARY

- Eczema
- Rosacea

MUSCULOSKELETAL

- Gout
- Osteoarthritis
- Paralysis, Type: _____
- Other: _____

NEUROLOGICAL

- Headaches
- Migraines
- Multiple Sclerosis
- Seizures

OCULAR

- Blindness
- Cataracts
- Cataract Surgery
- Contact Lenses
- Crossed Eyes
- Glasses
- Glaucoma
- Keratoconus
- Laser Eye Surgery
- Lazy Eye
- Macular Degeneration
- Ocular Injury/Trauma
- Other Eye Surgery
- Retinal Detachment

PSYCHIATRIC

- Anxiety
- Bipolar
- Depression
- Schizophrenia
- Other: _____

RESPIRATORY

- Asthma
- Chronic Bronchitis
- Emphysema
- Pneumonia

Other/Details: _____

General Surgeries: _____

Allergies to Medications: _____

Toyos Clinic - Medical History Questionnaire

Ocular History:

Date of your last eye exam: _____

Do you have glasses? (Please circle one) Yes / No

If yes, how old are your glasses? _____

Do your glasses have prism? (Please circle one) Yes / No / Unsure

Do you have contacts? (Please circle one) Yes / No

If yes, are you currently wearing your contacts? (Please circle one) Yes / No

How many years have you worn contacts? _____

What type of contacts do you wear? (Please circle one) Soft / Toric / RGP / Scleral

What brand of contacts do you wear? _____

Social History: (Please circle and indicate as necessary)

Smoking Status: Never Smoker / Former Smoker / Current Smoker -- Amount: _____

Alcohol Consumption: Heavy / Moderate / Occasional / Never

Recreational Drug Use: Yes / No

Medications: Please list all medications you are currently taking. Include eye drops, vitamins, and homeopathies. If you have a pre-printed list, please allow the front desk to make a copy.

Name of Drug	Dosage	What is the medication for?

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Patient's Signature: _____ Date: _____