TRUESIGHT
VISION CENTER

Patient Name: First_____ Last_____ Preferred name:_____

Today's Date: _____Address: _____

Date of Birth: _____Please Circle/Specify: Female Male _____

Occupation: _____Primary Doctor: _____Phone/Fax:_____

Primary Insured Name (if not patient): _____Date of Birth: _____

Medical Insurance: _____ Member ID:_____

EYECARE HISTORY

Last Eye Exam _____

Have you ever had eye surgery: Y N

Do you currently wear Contact lenses: Y N

Do you Currently use any prescription Eye drops: Y N

Would you Like to Try Contact Lenses: Y N

Please write name of drop:

Please list family member with Glaucoma:

Family member with Macular Degeneration:

MEDICAL HISTORY

Do you have:	Diabetes	Y	N	Thyroid Disease	Y	N	High Blood Pressure	Y	N
Do you:	Take Insulin	Y	N	High Cholesterol	Y	N	Drink Alcohol	Y	N

Do you Plan to get new glasses today: Y N

Do your eyes get watery: Y N

Do you have any difficulty with night driving: Y N

Do your eyes itch: Y N

Do you have Prescription Sunglasses Y N

Do your eyes feel pain/sore: Y N

Do you Smoke/Use Tobacco? Never Formerly Currently Some Days Currently Somedays

Please list your current medications (including over-the-counter medications)

_____

Please list any current allergies (including allergies to medications)

_____

What is your preferred pharmacy? (please include name and address)

_____

Notice of Privacy Policies & Consent Form

While providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4) other aspects of payment described in our Notice of Privacy Policies. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You may obtain an updated copy here at the office (or from our website truesightvisioncenter.com).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of this Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Truesight LLC dba Truesight Vision Center.

Payment Policy

It is our mission to provide you with the highest quality eyecare. In order to do this we must receive payment for our services in a timely manner. Our policy is to collect payment at the time of service. WE will file medical insurance for you when we are members of the provider panel. If we are not members, you will be required to pay for your services and/or products and then file for any reimbursement. If you have not met your insurance deductible, you will be required to pay for all products and services. We accept cash, personal check, money orders, Visa, MasterCard and Discover. All outstanding balances over 90 days old will begin to accrue interest at a 10% APR. We are available to discuss any questions or concerns that you may have regarding our payment and collection policy. We appreciate you as a patient and thank you for allowing us to continue to provide the highest quality eyecare.

Acknowledgement of Privacy & Payment Policies:

_____ _____ _____

Responsible Party Signature | Relationship to patient | Date

Please print patient name here_____

CONTACT INFORMATION

Our practice strives to correspond in the most efficient and timely manner when it pertains to patient communication. We offer the option of confirming appointments, reminders and sending occasional offers through electronic communication methods. Please help us update your records to provide these enhanced services.

_____ _____ Texting OK? (circle one)

Email Address | Cell Phone | Yes No