McMillian Eye Care

Welcome To Our Office

Name:_____ Date:_____

Street:_____

City:_____ State:_____ Zip:_____ Responsible Party, if other than patient

Phone:_____ Name:_____

Date of Birth:_____ Address:_____

Sex: Male_____Female_____ Phone:_____ Date of Birth: _____

Social Security#:_____

Spouse:_____ Vision Insurance:_____

Employer or School:_____ Medical Insurance:_____

Work#:_____ Primary Care Physician:_____

Cell#:_____ Address:_____

Email Address:_____

_____

For the purpose of notifying me of my protected health information such as test results, appointments dates and times, or other necessary contacts. This person or persons will only be notified when I cannot be reached.

I_____ permit McMillian Eye Care to contact

Name:_____ Phone:_____Relation:_____

Name:_____ Phone:_____Relation:_____

Signature:_____ Date:_____

Name:_____ **Date:**_____

Circle any of the following medical conditions that you currently have

Medical History

Anxiety	Bone Marrow Transplant	HIV/AIDS
Arthritis	COPD	High Cholesterol
Asthma	Depression	High Blood Pressure
Atrial Fibrillation (Irregular Heartbeat)	Diabetes Type 1 Type 2	Hyperthyroidism
Autoimmune Disease	GERD	Hypothyroidism
Type:_____	Hearing Loss	Seizures
Cancer Type:_____	Hepatitis	Stroke

Other:_____

Medical Surgery History:_____

Circle any of the following ocular conditions that you currently have

Ocular History

Diabetic Retinopathy	Ocular Hypertension	Cataract
Macular Degeneration	Dry Eyes	Vitreous Floaters
Glaucoma	Strabismus	Retinal Tear

Other:_____

Ocular Surgery History:_____

Current Medications

Please list all medications you are currently taking including over the counter

Medication	Dosage	Frequency

Medication Allergies

Smoking History: Current_____ Former:_____ Never:_____

Family History

	Mother	Father	Sister	Brother
Heart Disease				
Hypertension				
Diabetes				
Glaucoma				
Macular Degeneration				
Other:				

MCMILLIAN EYE CARE
JEFF McMILLIAN, O.D.
185 Wesley Reed Dr., Suite E
Atoka, TN 38004
Phone: (901) 840-EYES (3937)

CREDIT POLICY

SERVICES:

1. PAYMENT IS REQUIRED ON THE DAY OF SERVICE WITH THE FOLLOWING EXCEPTIONS:
   - A. SPECIAL ARRANGEMENTS HAVE BEEN MADE WITH THE ACCOUNTS MANAGER, OR
   - B. THE PATIENT HAS MEDICARE OR MEDICARE/MEDICAID.
     1. MEDICARE DEDUCTIBLE: MEDICARE REQUIRES YOU TO PAY A FEE EACH YEAR
     2. MEDICARE CO-PAY: MEDICARE REQUIRES YOU TO PAY 20% OF YOUR APPROVED CHARGES AFTER YOUR DEDUCTIBLE HAS BEEN MET.
   - C. THE PATIENT HAS COMMERCIAL INSURANCE, PAYS ALL CHARGES FOR THE DAY UP TO $100.00, ASSIGNS BENEFITS TO THE PHYSICIAN AND AGREES TO PAY THE REMAINING BALANCE NOT PAID BY INSURANCE 30 DAYS FROM THE DATE INSURANCE IS FILED BY OUR OFFICE.
2. ANY BALANCE REMAINING AFTER INSURANCE SHOULD BE PAID IN FULL WITHIN 30 DAYS OF THE DATE OF SERVICE. IF THE PATIENT OR RESPONSIBLE PARTY IS UNABLE TO PAY THE ACCOUNT IN FULL, THEY SHOULD CONTACT OUR ACCOUNTS MANAGER IMMEDIATELY FOR CONVENIENT TERMS. (ANY ACCOUNT BALANCE REMAINING UNPAID AFTER 90 DAYS FROM THE INITIAL BILLING DATE WILL BE SUBJECT TO TRANSFER TO A COLLECTIONS AGENCY. THE PATIENT OR RESPONSIBLE PARTY WILL BE REQUIRED TO PAY ANY EXPENSES INCURRED DURING THIS COLLECTIONS PROCESS.)
3. PATIENTS SHOULD ALSO UNDERSTAND THAT THE PHYSICIAN HAS THE RIGHT TO REFUSE FURTHER TREATMENT OF CLIENTS THAT REFUSE TO HONOR THEIR FINANCIAL RESPONSIBILITIES WITH THE CLINIC.
4. THE RESPONSIBLE PARTY WILL ACCEPT FULL RESPONSIBILITY IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE).

I HEREBY REQUEST THAT PAYMENT OF THE AUTHORIZED INSURANCE BE MADE DIRECTLY TO CAPE REGIONAL EYE CENTER. I AUTHORIZE CAPE REGIONAL EYE CENTER TO ACT AS MY AGENT TO HELP ME DETERMINE AND OBTAIN BENEFITS FROM MY INSURANCE COMPANY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS. I AGREE TO PAY ALL COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

CONTACTS:
ALL ORDERS MUST BE PAID IN FULL BEFORE DELIVERY.

I HAVE RECEIVED A COPY OF THIS CREDIT POLICY AND AGREE TO COMPLY WITH ALL POLICIES. I AGREE TO PAY ALL COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

_____ _____
PRINT NAME DATE

_____
SIGNATURE/ RESPONSIBLE PARTY

Notice of Privacy Practices for Protected Health Information

If you consent, the office is premitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care options. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for these services.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes. If you would like a copy of this 6 page privacy notice, please ask our receptionist.

By signing this form, I CONSENT TO TREATMENT for myself and/or on behalf of the Minor for which this information pertains. I GIVE PERMISSION for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment

Patient/ Parent or Guardian Signature

Today's Date