Talley Eye Institute

Demographic and Insurance Information
www.talleyeyeinstitute.com

Name: _____ **Today's Date:** ____/____/____ **Birthdate:** ____/____/____ **Age:** _____

Address: _____ **E-Mail:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Sex:** ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Social Security No.:** _____

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Employer: _____ **Work Phone:** _____

Notify in case of emergency: _____ **Phone:** _____ **Relationship:** _____

Family Doctor: _____ Phone: _____ Date of last doctor visit: ____/____/____

Referring Doctor: _____ Phone: _____

Is this a Workers' Comp injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Date of Injury: ____/____/____ Has the accident been reported to your employer? ☐ Yes ☐ No

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Contact Person: _____

Is this an Auto Liability Accident injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Where were you when injury/accident occurred? _____

What were you doing when injury/accident took place? _____

Auto Insurance Company Name: _____ Phone: _____

Contact Person: _____ Claim Number (if known): _____

Are you currently in a nursing home or rehabilitation facility? If yes, which? _____

Do you have someone designated as a power of attorney or medical power of attorney? If yes, Name: _____

Relationship to patient: _____

GUARANTOR INFORMATION

Name: _____ Relationship to patient: _____

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

Employer: _____ Work Phone: _____

Date of Birth: ____/____/____ Social Security No.: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

I understand that, even though I may have some type of insurance and authorize this office to submit charges on my behalf, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to me. I am aware that a co-payment may be required at each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a collection agency.

Signature _____ Date _____

Talley Eye Institute

Medical History Record

www.talleyeyeinstitute.com

Name: _____ Today's Date: _____ /_____ /_____ Birthdate: _____ /_____ /_____ Age: _____

Primary Care Provider: _____ Referring Doctor/Optometrist: _____

Current Ocular Problems

Do you currently have any problems in the following areas:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Blurred vision	☐	☐	Droopy eyelids	☐	☐	Eye pain/soreness	☐	☐	Floaters
☐	☐	Loss of vision	☐	☐	Dryness	☐	☐	Eyelid stye/chalazion	☐	☐	Glare/light sensitivity
☐	☐	Double vision	☐	☐	Excessive tearing/watering	☐	☐	Flashing lights	☐	☐	Infection of eye/eyelids
☐	☐	Distorted/wavy vision	☐	☐	Eye irritation						

☐ Other: _____

Are you noticing or having difficulty doing any of the following:

☐ Doing hobbies
☐ Driving at night
☐ Haloes/starbursts around headlights
☐ Reading small print
☐ Reading traffic signs
☐ Watching TV
☐ Other: _____

Past Ocular History

☐ No significant illnesses	☐ Corneal erosion	☐ Epiretinal membrane	☐ Glaucoma	☐ Ocular allergies
☐ Blepharitis/Rosacea	☐ Corneal ulcer	☐ Eyelid or facial spasms	☐ Herpes or Shingles	☐ Pterygium
☐ Blindness	☐ Diabetic retinopathy	☐ Eyelid turned inward	☐ Iritis	☐ Retinal tear/detachment
☐ Cataract	☐ Double vision	☐ Eyelid turned outward	☐ Macular degeneration	☐ Retinal vascular occlusion
☐ Chalazion/stye	☐ Droopy eyelid (ptosis)	☐ Foreign body removed	☐ Macular hole	☐ Uveitis
☐ Corneal abrasion/scratch	☐ Dry eye	☐ Fuchs' dystrophy	☐ Nerve palsy	☐ Vitreous hemorrhage

☐ Eye Injury: Which Eye? _____ Please describe: _____

☐ Other: _____

Past Ocular Surgery

☐ No prior eye surgery	☐ Eyelid surgery	☐ Pterygium surgery	☐ Retinal injections
☐ Cataract surgery	☐ Glaucoma surgery (incisional)	☐ Refractive surgery (LASIK, PRK, RK)	☐ Retinal laser
☐ Corneal surgery	☐ Glaucoma surgery (laser)	☐ Removal of eye	☐ Retinal surgery
☐ Eye muscle surgery	☐ Orbital surgery		

☐ Other: _____

Current / Past Medical Conditions

☐ Alzheimer's	☐ Dementia	☐ Kidney stones	☐ Sarcoidosis
☐ Anemia	☐ Depression	☐ Liver disease/cirrhosis	☐ Schizophrenia
☐ Anxiety	☐ Diabetes	☐ Lupus	☐ Seasonal allergies
☐ Asthma	☐ Difficulty Hearing	☐ Migraines/Chronic headaches	☐ Seizure disorder
☐ Atrial fibrillation	☐ Essential tremors	☐ Obesity	☐ Sickle Cell disease
☐ Bipolar	☐ Fibromyalgia	☐ Osteoarthritis	☐ Sjogren's syndrome
☐ Bleeding disorder	☐ Gastric reflux/GERD	☐ Paralysis	☐ Snoring/sleep apnea
☐ Blood clots	☐ Gout	☐ Parkinson's	☐ Stomach ulcers
☐ Claustrophobia	☐ Heart attack	☐ Prior head injury/Concussion	☐ Stroke
☐ Congestive heart failure	☐ High blood pressure	☐ Prostate hypertrophy (enlargement)	☐ Thyroid problems
☐ COPD/emphysema	☐ Irregular heartbeat	☐ PTSD	☐ TIA
☐ Coronary artery disease/angina	☐ Kidney disease/failure	☐ Rheumatoid arthritis	☐ Vertigo

☐ Cancer: What type? _____ Currently being treated? Yes No
How is it being treated? Chemotherapy Radiation Surgery

☐ Past Severe Injuries: _____

☐ Other condition not listed: _____

Other Past Surgery

☐ None	☐ Breast surgery	☐ Defibrillator	☐ Hysterectomy	☐ Pacemaker
☐ Amputation	☐ Cancer/tumor removal	☐ Face/Head	☐ Kidney surgery	☐ Sinus surgery
☐ Appendectomy	☐ Carotid artery	☐ Gastric Bypass	☐ Knee surgery	☐ Stomach surgery
☐ Back surgery	☐ Colon/intestinal surgery	☐ Heart valve surgery	☐ Mastectomy	☐ Thyroid surgery
☐ Brain	☐ Coronary bypass/open heart	☐ Hip surgery	☐ Other orthopedic surgery	☐ Tonsillectomy

☐ Other: _____

Infection History

☐ None	☐ Hepatitis C	☐ HIV/AIDS
☐ Chicken pox	☐ Herpes Simplex	☐ MRSA/VRE
☐ Chlamydia	☐ Herpes Zoster/Shingles	☐ Syphilis
☐ Hepatitis B	☐ Histoplasmosis	☐ Tuberculosis

☐ Other: _____

Family History

	Relationship to Patient		Relationship to Patient
☐ Blindness	_____	☐ Glaucoma	_____
☐ Cancer	_____	☐ Heart problems/heart attack	_____
☐ Diabetes	_____	☐ Macular degeneration	_____
☐ Fuchs' dystrophy	_____	☐ Retinal detachment	_____

☐ Other: _____

Social History

Do you drink alcohol? Yes No Do you use illegal drugs? Yes No Do you use marijuana? Yes No

Are you a: ☐ Current every day smoker How many packs per day? _____

☐ Former smoker? When did you quit? _____

☐ Never have smoked

What is your occupation? _____

If retired, what was your occupation? _____

Medications and Allergies

Please bring a list of your current medications with you to your visit or complete the attached medication list. Please make sure to include the name of the medication as well as the dosage and frequency.

Do you routinely take anticoagulant medications such as aspirin, coumadin/warfarin, Plavix, Eliquis, or Xarelto? Yes No

What pharmacy do you use? _____ Pharmacy Phone Number: _____

Do you have any allergies to medications? Yes No
If Yes, please list medications and reactions to them (includes difficulty breathing, confusion, cough, dizziness, headache, nausea/vomiting, hives/rash

Medication:	Reaction:
_____	_____
_____	_____
_____	_____

Have you ever had a reaction to an anesthetic? Yes No If Yes, describe your reaction/side effect: _____

Are you allergic to Latex? Yes No If Yes, describe your reaction (rash, difficulty breathing, hives, etc.) _____

Do you currently or have you ever used Flomax (Tamsulosin), Saw Palmetto, or Rapaflow? Yes No

Talley Eye Institute

Medication List

www.talleyeyeinstitute.com

Name: ______________________________________ Today's Date: _____ /_____ /_____ Birthdate: _____ /_____ /_____ Age: ____________

Please list all current medications that you are taking (including prescription medications, over-the-counter medications, herbals, vitamins, mineral supplements, dietary supplements, etc.). Attach a list if necessary.

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

Name:	Dosage:	How often?
By ☐ mouth ☐ injection ☐ patch ☐ _________	Prescribing Doctor:	Taken for?

TALLEY MEDICAL-SURGICAL EYE CARE ASSOCIATES
6149 E. Columbia St • EVANSVILLE IN 47715
812.424.2020 • 800.489.2020 • 812.424.3000 fax • www.talleyeyeinstitute.com

RESPONSIBILITY, CONSENT & ASSIGNMENT OF BENEFITS

MEDICAL CONSENT. I, the undersigned, being the person whose name appears hereafter designated as "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Talley Medical-Surgical Eye Care Associates, PC ("Doctor Office") to: (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by members of my doctor's staff as well as by the doctor him(her)self and this routine work-up often includes the instillation of eye drops for various reasons- such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students, nurses/nurse's aides, technicians and agents and employees of the Doctor Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here **does NOT** extend to initiation of any oral or IV medications nor any surgical procedures or injections performed whether in the Office or a surgical facility. Separate consent must be obtained for any of these procedures.

RELEASE OF INFORMATION. The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release same and copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier(s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

HIPAA NOTICE. I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information.

DISPOSITION OF TISSUE, ETC. I authorize the Doctor Office to retain, preserve, and use for scientific purposes or disposal at the convenience of the Doctor Office, any specimens or tissues taken during my treatment.

MEDICARE CERTIFICATION. I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I authorize my doctor who treats me, to release information from my medical records to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the processing of claims for medical benefits. I permit a copy of this authorization to be used in place of the original, and I request that payment of authorized benefits be made directly to my doctor treating me, on my behalf.

PAYMENT GUARANTEE. In consideration of the services delivered by the Doctor's Office and/or doctor, the undersigned guarantees payment of the account, and agrees to pay the same at the time of visit if such account is not paid by a private or governmental insurance carrier, and to pay any balance due promptly upon receipt of my first statement. I agree to comply with the terms of my insurance coverage, including payment of co-pays at the time services are rendered. I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party. I understand that the Doctor's Office may add a finance charge to any outstanding balance. If the amounts due to the Doctor's Office for services rendered become delinquent and do not have agreed upon financial arrangements with the Doctor's Office, these accounts may be submitted to a collection agency or attorney for collection. I agree that I will pay all attorney fees and court costs incurred by the Doctor Office in the collection of all sums due. If I provide the Doctor Office or its agents with my cell phone number, I authorize the Doctor Office or its agents to call our cell phone either manually or by auto-dialer in order to collect any amounts that I owe. I understand that any email that I provide is my personal email and I authorize the Doctor Office to contact us via that email address.

MEDICAID. If this service is to be covered under a Medicaid Program, I understand that I must show my current Medicaid card prior to seeing the doctor, and to pay any spend down that has not been met at time of service. I agree and understand that if I am a QMB recipient, that Medicaid will extend coverage to payment of Medicare co-insurance and/or deductible only, and that I am responsible for services and supplies not covered or denied by Medicare. I further agree and understand that I am being informed, prior to receipt of service, that I may be responsible for services that the Indiana Medicaid Program determines not to be a covered benefit. I agree and understand that if I do not have my current Medicaid card that payment in full is required for this visit at the time services are rendered.

ASSIGNMENT OF BENEFITS. In consideration of services rendered to be rendered from time to time by Doctor, I hereby authorize, request, and assign payment directly to the Doctor's Office and/or Doctor covering this period of treatment and future treatment, by all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance benefits which exist by reason or contract or otherwise, including but not limited to, Major Medical and other special coverages, and including the right to sue or make claim for said benefits; this assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between the Doctor Office, and the undersigned; this assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness. In the event that insurance benefits to which I am entitles are paid directly to me for indebtedness incurred by me or a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefit received.

PRIOR AUTHORIZATION. I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. NOTICE: Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services under your plan. Please be sure to review your health care insurance plan before receiving any services at the Doctor's Office. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage's and any restrictions on choosing a provider. Talley Medical-Surgical Eye Care Associates offers a full range of the services you may need; however, in order to receive maximum insurance payment, you need to know your health insurance benefits coverage and which providers the insurance will fully pay.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

_____	_____	_____
Signature of Patient / Legal Representative	Date	Relationship of Legal Representative

_____	_____	_____	_____
Signature of Guarantor (if other than above)	Date	Signature of Witness	Date

_____	_____
Policyholder (if other than Guarantor)	Date

Talley Eye Care

Authorization for Release of Identifying Health Information

From time to time we may have to call you on the phone or we may receive a call from your family or caregiver. Please let us know your wishes with regards to whom we may speak with about your upcoming appointments, test results, or exam findings.

You are allowing us permission to speak with the following individuals about your Protected Health Information (PHI):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We may discuss the following with these individuals (please check all boxes that apply):

- ☐ **Your Appointment Date, Time, Location, and Doctor's Name**
- ☐ **Your Test Results**
- ☐ **Your Exam Findings**
- ☐ **Other _____**

If you wish to add or remove individuals from this list, we ask that you let us know about this decision at your earliest convenience.

It is completely your decision whether or not to sign this form. We cannot refuse to treat you if you choose not to sign. If you sign now you may revoke it later by sending a written request to our office at Talley Medical Surgical Eye Care Assoc. PC, 6149 East Columbia St., Evansville, IN 47715

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described on this form.

Patient (or legal guardian) signature: _____Date: _____

Printed Name: _____

If you are the legal representative of the patient that you are signing for, describe your relationship to the patient and the source that gives you legal authority to sign this form:

Relationship to patient: _____ Printed Name: _____

Source of authority: _____ Witness: _____

Referral Notice

Patient Name: _____ Date of Birth: _____

In the course of providing care to you, your doctor may want to refer you to another provider for additional health care or services.

When we refer you to another provider please be advised:

1. That an out of network provider may be called upon to render health care items or services to a patient during the course of treatment.
2. That an out of network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.
3. That the patient may contact his/her health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.

This does not apply in the following situations:

1. For treatment of an emergency medical condition
2. A referral made immediately following treatment of an emergency medical condition and by the provider that rendered the treatment of the emergency medical condition.
3. A referral for medically or psychologically necessary therapeutic services rendered to an admitted patient in a hospital or another facility to which a patient may be admitted for more than twenty-four (24) hours.
4. A referral made by a provider that has confirmed that the provider to which a covered individual is referred is a network provider with respect to the patient's health plan.

_____ _____

Signature Date