



WELCOME TO TRI-COUNTY EYE CLINIC

Thank you for choosing Tri-County Eye Clinic as the provider for your eye care. You have an appointment at one of the following two locations: 15122 Dedeaux Road, Gulfport, MS; or 431 Bertucci Blvd, Biloxi, MS. Please plan to arrive at least 15 minutes prior to your appointment time.

Your appointment time is: _____ am / _____ pm on _____

If you have any questions regarding this appointment, please call our Biloxi Office at (225) 385-2020, or Orange Grove (228) 832-1242.

Completing the attached forms will make your waiting time considerably less:

- (1) **Patient Registration Form:** Please carefully read and complete the and bring with you at the time of your visit
- (2) **Patient / Family Health History:** Again, please carefully read and complete this form and bring with you at the time of your visit.
- (3) **HIPAA Notice of Privacy Practices:** Please review carefully as this Notice describes how medical information about you may be used and disclosed, then sign and date.
- (4) **Financial Policy Acknowledgment:** Please review, then sign

Note: Please bring the above documents with you to the appointment.

Other information required:

- Picture ID: We will need a picture ID or driver's license for your file.
- Insurance Card(s): Bring all insurance cards with you at each visit. We will make copies and file the necessary claims if we are providers with your carrier.
- If your insurance requires a referral, please call your Primary Care Physician prior to your visit and make appropriate arrangements.

Financial Policy Overview:

BE PREPARED TO PAY ALL APPLICABLE FEES AT THE TIME OF CHECK IN.

- Insurance co-payment.
- Deductibles that are unmet at the time of visit.
- If you have Medicare only, the 20% for which the patient is responsible.
- Routine eye care which is not covered by insurance companies.
- Fees for refraction (testing to determine your eyeglass prescription).
- Fees for any additional testing or treatments are paid at check out.

If you have questions regarding our Financial Policy, please call and speak with a member of our Insurance Department at 225-594-9462. Our staff is always happy to answer your questions and discuss your concerns.

Tri-County Eye Clinic – Patient History

Patient's Name _____

Date _____

PATIENT / FAMILY HEALTH HISTORY

Do you or a blood relative have a history of:

	Patient	Family		Patient	Family
Retinal Detachment	YES/NO	YES/NO	Glaucoma	YES/NO	YES/NO
Crossed or Lazy Eye	YES/NO	YES/NO	Cataract	YES/NO	YES/NO
Night/Color Blindness	YES/NO	YES/NO	Patching	YES/NO	YES/NO
Macular Disease	YES/NO	YES/NO	Diabetes	YES/NO	YES/NO
Sickle Cell Disease	YES/NO	YES/NO	Cancer	YES/NO	YES/NO
High Blood Pressure	YES/NO	YES/NO	Heart Disease	YES/NO	YES/NO
Thyroid Condition	YES/NO	YES/NO	Blindness	YES/NO	YES/NO
HIV/AIDS	YES/NO	YES/NO			

Other family medical problems: _____

PAST EYE HISTORY

Have you ever had any serious eye disease, eye injury or eye surgery? Yes No

If yes, please explain _____

Do you wear contact lenses? Yes No If yes, which type? Hard Soft Disposable

How old is this pair? _____

Date of Last eye exam and Eye Doctor's Name: _____

PAST MEDICAL HISTORY

Have you ever had any surgery? Yes No

If YES, please provide date and reason: _____

Have you ever been hospitalized? Yes No

If YES, please provide date and reason: _____

Do you take any medications? Yes No

If YES, please list: _____

Do you use any eye medications? Yes No

If YES, please list: _____

Do you have any drug or food allergies? Yes No

If YES, please list: _____

FAMILY AND SOCIAL HISTORY

Do you smoke? Yes No If YES, how much _____ Drink? Yes No If YES, how much? _____

If employed how many hours per week do you work? _____

Comments: _____

Patient's Signature: _____

Tri-County Eye Clinic – Patient History

REVIEW OF SYSTEMS

Do you currently have any of the following problems:

	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Problems (e.g. heartburn, abdominal pain, diarrhea, Vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems (e.g. rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Problems (e.g. muscle aches, joint pain, Swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Problems (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

PATIENT'S VISUAL SYMPTOMS

(check each you have had)

<input type="checkbox"/> None, Periodic Eye Exam	<input type="checkbox"/> Variable Vision	<input type="checkbox"/> Red Eyes
<input type="checkbox"/> Distance Blurred Vision	<input type="checkbox"/> Temporary Loss of Vision	<input type="checkbox"/> Itching Eyes
<input type="checkbox"/> Near Blurred Vision	<input type="checkbox"/> See Flashing Lights	<input type="checkbox"/> Watery Eyes
<input type="checkbox"/> Discomfort at distant visual tasks	<input type="checkbox"/> See Floaters or Spots	<input type="checkbox"/> Dry Eyes
<input type="checkbox"/> Discomfort at near visual tasks	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Twitching Eyelids
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Headaches related to eyes	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Burning Eyes	

	YES	NO		YES	NO
Do you have more than 1 pair of current Rx glasses?	<input type="checkbox"/>	<input type="checkbox"/>	If you wear contact lenses, are you satisfied with vision and comfort?	<input type="checkbox"/>	<input type="checkbox"/>
Do you work on a computer for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>		Are you interested in a "test drive" of the latest contact lens design(s)?	<input type="checkbox"/>
If you wear glasses, would you benefit from thinner lighter lenses?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you spend a lot of time outdoors?	<input type="checkbox"/>	<input type="checkbox"/>			
If you wear bifocals, are you bothered by restricted windows, lines or head tilting?	<input type="checkbox"/>	<input type="checkbox"/>			
Are there times you'd rather not wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>			

PLEASE CHECK THOSE ACTIVITIES IN WHICH YOU PARTICIPATE AND INDICATE NUMBER OF TIMES A MONTH TO THE RIGHT

Golf _____	Soccer _____	TV _____	Crafts _____
Basketball _____	Swimming _____	Walking _____	Musical inst. _____
Skiing _____	Hunting _____	Jogging _____	Scuba _____
Football _____	Fishing _____	Rollerblade _____	Sewing _____
Baseball _____	Bowling _____	Dancing _____	Woodwork _____
Softball _____	Volleyball _____	Aerobics _____	Boating _____
Tennis _____	Cards _____	Reading _____	
Racquetball _____	Biking _____	Gardening _____	
Other (please list) _____			

PATIENT'S SIGNATURE

DATE:

REVIEWED BY:

HOW MANY HOURS A DAY DO YOU USE A COMPUTER? _____

DATE:

TRI-COUNTY EYE CLINIC --- PATIENT REGISTRATION FORM

Patient Information

First	M.I.	Last	Title
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	S.S. #
Birth date	Age	Sex (circle one) M F	Marital Status
Patient Employer		Patient's Occupation	
E-Mail Address	Parent/Guardian Name	Spouses Name	Spouses D.O.B.

Insurance Information

Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Name	ID #	Group #	Birthdate
Secondary Insurance Company			
Address	City	State	Zip
Insured's Name	ID #	Group #	

HOW WERE YOU REFERRED TO OUR CLINIC: (PLEASE CHECK ONE)

- NEWSPAPER
 PATIENT OF OURS
 RADIO
 OUR SIGN
 DIRECT MAIL
 HOSPITAL
 PHYSICIAN
 EMPLOYER PPO LIST
 YELLOW PAGES
 RELATIVE/FRIEND
 T.V.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, non-covered procedures, or any other balance not paid for by your insurance company.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS OR CO-PAYMENTS BE PAID AT THE CONCLUSION OF EACH VISIT.

We will allow a 60-day grace period for your insurance company to pay. After the account has reached 60 days old, the balance will be transferred to patient due and a 1.5% monthly interest charge will be applied until the balance is paid in full. After the account has reached the 120-day status, the account will be turned over to a collection agency as a bad debt.

If this account is assigned to an attorney or agency for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection (which is 33% of the account balance). To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits; to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance and other health plans to TRI-COUNTY EYE CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment. This signature also authorizes any medical treatment by Tri-County Eye Clinic doctors deemed medically necessary to obtain proper care and diagnosis.

I am paying for Today's visit by: Check Cash Credit Card (**MasterCard, Visa, or Discover**)

Signed

Date

Witnessed

HIPAA Notice of Privacy Practices

Tri County Eye Clinic

15122 Dedeaux Road
Gulfport, MS 39503
228-832-1242

431 Bertucci Blvd
Biloxi, MS 39531
228-385-2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Patient's Signature

Date Signed

Tri-County Eye Clinic

Gregory E. Bertucci, M.D.
Philip L. Bertucci, M.D.
C. Curtis Gipson, M.D.
Allen J. Koskan, M.D.
Alan J. Franklin, M.D.
Roderick D. Fields, O.D.

15122 Dedeaux Road
Gulfport, MS 39503
(228) 832-1242
431 Bertucci Blvd
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(228) 385-2020

Financial Policy Acknowledgment

Dear Valued Patient,

We at Tri-County Eye Clinic specialize in caring for your eyes. We are very good at what we do. Many patients come to us to evaluate and treat conditions of the eye.

We have been asked to accept 2,400+ different insurance policies. We accept your promise to pay when you present a card however you will ultimately be responsible for any amount that your insurance company does not pay. **Please do not ask our staff nor our doctors if your insurance company will pay benefits if you are seen and treated by one of our doctors.** They are not qualified to know your insurance benefits. It is **your** responsibility to know your benefits.

Your benefits offered by many insurance companies vary depending on which doctor you see, depending on whether the company is primary or secondary and various other combinations. You will have to pay what the insurance company does not pay.

We have a phone available for you to call to verify coverage **before** you are seen by the doctor. We will **not** accept the responsibility for determining your coverage. **We encourage you to verify your coverage with your own insurances prior to being seen.**

We do agree to bill your insurances for you only as a courtesy. If they do not pay your claim in a reasonable period of time (30 days) we will expect you to pay us and deal with the insurance yourself. I hereby authorize TCEC to release any information necessary to secure payment.

I have read the above and understand that I am ultimately responsible for paying for the services that I receive. If for any reason, my insurances do not pay for my services, I agree to pay the Clinic directly and will not hold your staff, including receptionists, doctors, or telephone operators responsible for my company not paying my bills.

Patient's Signature

Date Signed