

# EYE TO EYE CLINIC

WILSONVILLE OFFICE  
8269 SW WILSONVILLE RD., SUITE C  
WILSONVILLE, OR 97070  
(503) 685-9015

DR. W. TODD BRISCOE DR. ROSILAND HURSH  
DR. LORNE YUDCOVITCH  
OPTOMETRIC PHYSICIANS

WEST LINN OFFICE  
22400 S. SALAMO RD., SUITE 100  
WEST LINN, OR 97068  
(503) 722-7737

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 SSN \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Occupation \_\_\_\_\_ Marital Status (*circle one*) S M D W  
 Employer \_\_\_\_\_  
 Emergency contact/telephone number \_\_\_\_\_  
 Date of last eye exam \_\_\_\_\_ Dilated? \_\_\_\_\_ Today's date \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

**Medical Information / Review of Systems**

List any **medications** you currently take (prescription and over the counter):  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have **allergies** to any medications?  Yes  No  
 If YES, list the medications:  
 \_\_\_\_\_  
 \_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you **currently** have any problems in the following areas? If "Yes," please provide information.

	YES	NO	Explanation of Problem
<b>EYES</b> (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Flashes/Floaters in vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Tired eyes			
Crossed eyes, lazy eye			



# Eye to Eye Clinic Wilsonville

Dr. W. Todd Briscoe • Dr. Rosiland Hursh • Dr. Lorne Yudcovitch  
Optometric Physicians

8269 S.W. Wilsonville Road, Suite C  
Wilsonville, OR 97070

## CREDIT POLICY

AS A SERVICE TO OUR PATIENTS, WE WOULD LIKE TO OUTLINE OUR POLICY TOWARDS THE PAYMENT FOR SERVICES RENDERED.

1. As a courtesy to you, your **PRIMARY INSURANCE** will be billed, provided the necessary **ID, Group Numbers and billing address** are provided **at the time of visit**, unless other arrangements have been previously made. However, **after 45 days**, the balance of the bill becomes **YOUR** responsibility.
2. Although we are billing insurance companies, we hold you responsible for your account.
3. Any services / materials considered to be a “**non-covered benefit**” by your insurance company will be billed to you.
4. Insurance **co-pays** are required at the time of the office visit. If your co-pay is **NOT** made at the time of your office visit, you will be subject to a \$15 collection fee, which will be applied to your account.
5. We realize that many families are in a state of change. Divorces, separations, single parents and blended families are now common. In many of those families, the question of who is responsible for the children’s care is uncertain. Our policy is that **the parent who requests treatment** for the child is responsible for all fees incurred.
6. We encourage you to contact our billing/crediting department if you have any questions regarding your account. We will be happy to set up a payment plan with you if needed. Once an arrangement has been made, you will be expected to follow that plan.
7. Your signature authorizes us to contact any reference in case it becomes necessary to locate you.

I HEREBY AUTHORIZE THE ABOVE DR/DRS. TO FURNISH THE INSURED’S INSURANCE COMPANY ALL THE INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY CLAIMS FOR SERVICES.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE INSURANCE COMPANY.**

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Responsible party’s signature

-----  
Date

# ACKNOWLEDGMENT AND CONSENT

Eye to Eye Clinic  
8269 S.W. Wilsonville Road, Suite C, Wilsonville, OR 97070

I understand that the Eye to Eye Clinic (referred to below as "The Practice") will use and disclose **health information** about me. I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	