TICHO EYE ASSOCIATES

(708) 873-0088

Patient Information

(Please Print Legibly & Fill In or Correct All Fields)

Would you like to be checked for glasses and/or contacts today? Yes_____ No_____ This test is called a REFRACTION, it is a necessary part of the exam that is not covered by commercial insurances & Medicare. The fee for a refraction is $40.00. If you have Eyemed please let us know at time of service.

N/A for Medicaid patients

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____

E-mail _____

Age _____ Birthdate ____/____/_____ Sex ❒ Female ❒ Male

Emergency Contact _____ Relationship to Patient _____

Home or Cell Phone _____

Primary Health Insurance Company _____

Responsible Party or Insured Name: _____ **DOB** _____

Primary Care Physician Name: (Required) _____ ( ) -_
Doctor's Office Phone Number (Required)

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

Signature _____ **Date** _____

Ticho Eye Associates
General Consent for Care and Treatment Consent (Adult and Minor)

Name of Patient: _____DOB: _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X_____ _____
Signature of Patient or Personal Representative **Date**

X_____ _____
Printed Name of Patient or Personal Representative **Relationship to Patient**

X_____ _____
Printed Name of Witness Employee **Date**

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of **Ticho Eye Associates** Notice of Privacy Practices. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

_____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient

_____

Printed Name of Personal Representative (if applicable)

Ticho Eye Associates Financial Agreement Acknowledgment

I acknowledge that I have read and received a copy of Ticho Eye Associates Financial Agreement.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

****Appointment Cancellation Policy Agreement****

Please Note:

Ticho Eye Associates is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (708) 873-0088 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $50.00 for the missed appointment.

Please sign below to consent to these terms.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Date