Phone 423-239-5491
Fax 423-239-4860
4617 Fort Henry Drive
Kingsport, TN 37663

McMillin eyecare
Focused Excellence

William C. McMillin, OD
William P. McMillin, OD
Katherine Randolph, OD
Brenna Jeffries, OD

PATIENT INFORMATION

First Name (Legal) _____ Last Name _____ Nickname _____

Street Address _____ City _____ Zip Code _____

Billing Address (if different) _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Receive Text? yes ___ no ___

Date of Birth _____ Social Security # _____ E-Mail Address _____

Gender _____ (**Please Circle Appropriate Response**)

Marital Status: Single, Married, Widowed, Divorced, Other

Patient's Place of Employment _____ Occupation _____

Name of Spouse _____ If under 18, Parent's/Guardian's Name _____ DOB _____

Employer of Spouse or Guardian _____ Relationship to Patient _____

OTHER INFORMATION

Preferred Pharmacy _____ Location _____

Patient Medical Doctor _____ Location _____

Specialty Medical Doctor _____ Location _____

VISION INSURANCE INFORMATION

Primary Vision Carrier _____

Insured Name _____

Insured Birth Date _____

Insured ID # _____

Patient's Relationship to Insured _____

Secondary Vision Carrier _____

Insured Name _____

Insured Birth Date _____

Insured ID # _____

Patient's Relationship to Insured _____

MEDICAL INSURANCE INFORMATION

Primary Medical Carrier _____

Insured Name _____

Insured Birth Date _____

Insured ID # _____

Patient's Relationship to Insured _____

Secondary Medical Carrier _____

Insured Name _____

Insured Birth Date _____

Insured ID # _____

Patient's Relationship to Insured _____

***We are a participating member of Medicare and we accept most vision and medical insurance plans. If we are not on your insurance plan, please let us know and we will do our best to offer you the same benefits.**
I authorize this office to release any information needed to process any insurance claim. I understand that I am responsible for any charges regardless of insurance coverage.

Signature of responsible party _____ Date _____

Our Mission is to treat each patient as an individual and to provide the highest quality vision care possible. We offer you and your family a lifetime commitment to the vision and health of your eyes.

PATIENT MEDICAL/VISION INFORMATION

NAME _____ **DOB** _____ **DATE** _____

Do you have or have you ever had the following eye conditions? If so, please explain.					
CATARACTS	Y / N		ITCHING	Y / N	
MACULAR DEGENERATION	Y / N		TEARING	Y / N	
GLAUCOMA	Y / N		DISCHARGE	Y / N	
DIABETES (circle: Type 1 Type 2)	Y / N		BLURRED VISION	Y / N	
DIABETIC RETINOPATHY	Y / N		EYESTRAIN	Y / N	
DRY EYES	Y / N		EYE PAIN	Y / N	
FREQUENT EYE INFECTIONS	Y / N		SEVERE SENSITIVITY TO LIGHTS	Y / N	
FLASHES/FLOATERS	Y / N		HEADACHES	Y / N	
IRITIS OR UVEITIS	Y / N		POOR NIGHT VISION	Y / N	
RETINAL DISEASE, TEARS, OR DETACHMENT	Y / N		BOTHERSOME NIGHT GLARE	Y / N	
REDNESS	Y / N		DOUBLE VISION	Y / N	
BURNING	Y / N		BLINDNESS	Y / N	
Please describe any eye injuries or eye surgeries.					

Do you have or have you ever had the following medical conditions? Please circle the condition and explain if needed.		
Developmental Delays / Cancer / Fatique Syndrome		
Hearing Loss / Sinusitis / Dry Mouth / Laryngitis		
Multiple Sclerosis / Epilepsy / Cerebral Palsy / Tumor / Stroke / CVA / Migraine / Autism Spectrum Disorder		
Depression / Attention Deficit Disorder / Anxiety Disorder /Bipolar Disorder		
Hypertension / Stroke / Heart Disease / Vascular Disease / Congestive Heart Failure		
Cigarette Smoker / Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea		
Crohns / Colitis / Celiac Disease / Ulcer / Acid Reflux		
Kidney Disease / Prostate Disease or Cancer / STD-Herpetic / Chlamydia / Benign Prostate Hypertrophy / Currently Pregnant or Nursing	Y / N	
Arthritis / Osteoarthritis / Fibromyalgia / Muscular Dystrophy / Ankylosing Spondylitis / Osteoporosis / Gout		
Eczema / Rosacea / Psoriasis / Herpes Simplex / Cold Sores / Herpes Zoster / Shingles		
Type 1 or 2 Diabetes / Thyroid Dysfunction / Hormonal Dysfunction		
Anemia / Blood Loss / Ulcer / High Cholesterol		
Drug or Environmental Allergies / Rheumatoid Arthritis / Lupus / Sjogrens		
OTHER		

PLEASE LIST ALL MEDICATIONS OF ANY KIND THAT YOU ARE CURRENTLY TAKING ALONG WITH THE DOSAGE, OR ATTACH A MEDICATION LIST. _____

PLEASE LIST ANY ENVIRONMENTAL OR DRUG ALLERGIES YOU MAY HAVE. _____

Is there any family history of the following? If so what relation. M-Mother F-Father B-Brother S-Sister GP- Grandparents D-Daughter Son-Son							
CANCER	Y	N		CATARACTS	Y	N	
DIABETES	Y	N		MACULAR DEGENERATION	Y	N	
HIGH BLOOD PRESSURE	Y	N		GLAUCOMA	Y	N	
THYROID ISSUES	Y	N		OTHER			

Health Habits: (This information is kept strictly confidential) Do you smoke or use tobacco products? (yes or no) Do you drink alcohol? (yes or no) Do you use any kind of illegal drugs? (yes or no) Have you ever been infected with Gonorrhea, Hepatitis, HIV or Syphillis? (yes or no) _____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

McMillin eyecare

Financial responsibility

Thank you for choosing McMillin Eyecare to be your provider. We are committed to providing high quality care and service to all our patients.

If applicable, by my signature below, I authorize McMillin Eyecare to bill my insurance company for services rendered and/or materials purchased. ***If the insurance company does not pay the claim and/or if they pay only a portion of the claim, I understand that I am responsible for paying the remaining balance.***

All balances must be paid in full before materials can be released. We **do not** have payment plans available but do accept all major credit cards and Care Credit for your convenience.

_____ _____

Signature of patient or guardian Date

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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 a 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 of 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.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMATION. 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 mange 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 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. 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: Worker's 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.