



TULMAN EYE GROUP
ADULT & PEDIATRIC OPTOMETRY

Welcome To Our Office

Ms. _____
Mr. _____
Miss _____
Patient's Name: Dr. _____ Other _____
Last _____ First _____ Middle _____ Nickname _____
(_____)

Date of Birth _____ Phone: Bus _____ Home _____
Cell _____

E-Mail _____ Apt No. _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

SS Number _____ Spouse's Name _____

If Child, Parent(s) or Guardian(s): _____

Father _____ Phone _____

Mother _____ Phone _____

Address if different from above _____

Whom may we thank for referring you to us? _____

Previous Eye Doctor _____ Date of last Exam _____

Do you wear glasses? _____ Contact Lenses? _____ Firm _____ Soft _____ Disposable _____

Are You Interested In Contact Lenses? Yes ___ No ___ Lasik Surgery? Yes ___ No ___

Person to Notify In Case of Emergency: (Not at same address) _____

Phone Number _____ Relationship _____

Please check your preferred method of payment:

Cash _____ Check _____ Mastercard/Visa _____

I. VISION PLAN:

___ VSP _____ GM-COLE _____ Spectra
___ Davis _____ Eyemed _____ Vision Care
___ Other _____

II. MEDICAL INSURANCE:

Primary Insurance:
 Medicare Medicaid TriCare Workman's Comp. PHCS
 BC/BS United Health Care Aetna/US Healthcare
 Cigna HMO/POS Cigna PPO State Merit Other: _____
 Policy Holder's Name _____

Please present insurance card and any secondary/supplemental insurance information.

III. AUTHORIZATION:

Medical Insurance Authorization:

I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize release of any medical information necessary to process this claim and also certify that the information contained herein is correct.

Signature **X** _____ Date _____

Lifetime Authorization - Medicare:

Signature **X** _____ Date _____

Payment is due when services are rendered. A finance charge of 1 1/2 % PER MONTH (18% per year) will be billed on unpaid balances greater than 30 days old. Please feel free to discuss our policies and fees with us. We strive to be responsive to our patient's needs and concerns.

We are pleased you have chosen us for your eye care. It is our policy to provide you with the best eye health and vision care possible. Again, welcome to our practice, we are here to be of service to you, your relatives and neighbors when the need for eyecare arises.

Medical History Questionnaire



TULMAN EYE GROUP

ADULT & PEDIATRIC OPTOMETRY

WestPark Professional Bldg.

880 Crestmark Drive, Ste. 101 • Lithia Springs, Ga 30122

(770) 948-0036

www.tulmaneyegroup.com

Name: _____ Date: _____

Birth Date: ____/____/____ Social Security # ____/____/____
Month Day Year

Last Eye Doctor: _____

Last Eye Exam: ____/____
Month Year

Current Medical Dr(s): _____

Last Medical Exam: ____/____
Month Year

Medical History

Do you have any allergies including medications, food, seasonal, etc.? Yes No If yes, explain: _____

List any medications (including oral contraceptives, aspirin, over-the-counter medications, eye drops and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? Yes No

Check any of the following that you have had: Reading Difficulty Crossed Eyes Lazy Eye Glaucoma
 Retinal Disease Cataracts Eye Injury Macular Degeneration Other _____

Do you wear glasses? Yes No If Yes, how old is your present pair of glasses? _____

How many pair of glasses do you currently use? _____

Do you wear contact lenses? Yes No If No, Are you interested? Yes No

If Yes, how old is your present pair of contacts? _____ Do you sleep in your contact lenses? Yes No

Type of contact lenses: Gas Perm. Soft Extended Wear Other Are they comfortable? Yes No

Have you had cataract surgery? Yes No If Yes, R L

Have you had refractive (LASIK / PRK / RK) surgery? Yes No Interested? Yes No

At work: Do you perform fine or close-up work? Yes No Is safety protection a concern at work? Yes No
 Are you outdoors all or part of the time? Yes No

Are you bothered by the glare from:

Overhead lighting? Yes No Oncoming headlights at night? Yes No A computer screen? Yes No

Do you have trouble reading signs when driving at night? Yes No

Are you sensitive to bright sunlight? Yes No

What hobbies or recreational sports do you enjoy?

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition

Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Retinal Detachment/Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

Relationship To You

Systemic Disease / Condition

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

* Please turn this form over and complete Side 2 *

TULMAN EYE GROUP



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ADULTS & PEDIATRIC OPTOMETRY
DANIEL J. TULMAN O.D., P.C.
MEHRDAD E. SAADAT, O.D.

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LITHIA SPRINGS, GA 30122
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VISION SOURCE
www.tulmaneyegroup.com

FAMILY VISION CARE
DIAGNOSIS & TREATMENT OF EYE DISEASE
COMPREHENSIVE CONTACT LENS CARE
PRE & POST-OP CATARACT/LASIK MANAGEMENT
AMBLYOPIA & STRABISMUS THERAPY

We are excited to announce that we have incorporated into our practice a new, highly sophisticated instrument that allows us to provide a more thorough medical analysis of your eyes.

Our **Optomap** Retinal System captures a digital image of the central and peripheral retina including blood vessels, optic nerve and macula and permanently stores it in the computerized data base for analysis and future comparison.

Unfortunately, routine eye exams do not detect many diseases in their early stages. The wide angle retinal scan can assist us in the early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy, retinal detachments, optic nerve disease, eye cancer and retinal disturbances due to vascular problems or medication.

We strongly recommend that all of our patients receive this procedure, just the way regular mammograms are indicated. It is especially important for people who have:

- 1) Headaches/Migraines
- 2) Spots or flashes of light.
- 3) A family history of Diabetes
- 4) A family history of High Blood Pressure
- 5) A family history of Glaucoma or Retinal problems
- 6) Strong eyeglasses prescription

This state of the art procedure only takes an additional 4 minutes of your time, and there is an additional charge for this imaging. This charge is in addition to any insurance co-payments or deductible you may have.

Please check the appropriate line below and sign the bottom.

- I want the **Optomap** Digital Retinal Imaging \$29.00
 I do NOT want this medical test.

PATIENT'S SIGNATURE _____ **Date** _____

Effective date of notice: _____

NOTICE OF PRIVACY PRACTICES

Daniel J. Tulman, O.D, P.C.

Mehrdad E. Saadat, O.D.

880 Crestmark Dr. Ste. 101

Phone # 770-948-0036

Fax # 770-948-0090

www.tulmaneyegroup.com

Contact person: Cheryl Jones

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; referring you to another doctor or for eye care or low vision aides or services; or getting copies of your health records from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personal decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our offices for these reasons, [we will] [we usually will not] ask you for special written permission.

[We will ask for special written permission in the following situations: _____.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your care with your family you friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." Federal law determines the content of an "authorization form". Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure if you do sign one; you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of the Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax, or E-Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as phoning you at work rather than at home, by mailing health information to a different address, or by using E Mail to your personal Email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.
- Ask to see or get photocopies of your health records. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if information is stored off site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorizations; incidental disclosures; disclosures required by law; and some limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you in writing. If you want a list, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

COMPLAINTS

If you think we have not properly respected the privacy of your health information, you are free to complain to us or the U>S> Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Daniel J. Tulman, O.D., Mehrdad Saadat, O.D.
Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____