NASHVILLE VISION ASSOCIATES

We appreciate your choosing our practice for your eye care health!

Please **complete and bring** the enclosed forms to your appointment:

- New patient Registration Form
- Medical History (front) and Medication List (back)
- Notice of Privacy Practices Receipt Acknowledgement

Please also bring:

- Glasses that you currently wear
- Wear your contacts and bring current boxes
- Current Medical Insurance Cards**
- If you have Healthspring, Aetna HMO, Cigna HMO, Cigna Connect, or *any other plan* that requires a **referral** from your primary care physician, you must have them fax it to us at **615.915.5074** prior to your appointment.

** We are a medical practice and participate with many medical plans. It is the patient's responsibility to verify coverage for the provider scheduled with prior to coming in for the appointment by calling the customer service number on their insurance card.

Vision Plans – as a group we do not participate in Vision Plans. Drs. Jerkins, and Bounds are providers for the EYEMED vision plan only. If you have EYEMED in addition to your medical insurance, you MUST bring proof of coverage/card with you in addition to your medical insurance cards. Claims may be filed as a courtesy if coverage information is provided.

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Visit our website at www.nashvillevision.com for more information about our office, providers, locations, services and frequently asked questions prior to your visit.

We look forward to meeting you soon!

NASHVILLE VISION ASSOCIATES

Explanation of Refraction Services

One of the most important parts of a comprehensive eye exam is the refraction. Refraction is the part of the exam by which we determine the best visual acuity and function of your eyes, which is essential medical information for us to assess your eyes. It also lets us know if we can improve your vision with corrective lenses and provides the glasses prescription to do so. It is not a covered service by Medicare and most other insurance plans. These plans consider this a **vision service** not a **medical service**.

The refraction service fee is ***$35.00*** and is collected at the time of service. Should your insurance pay for this service we will reimburse you accordingly.

Explanation of Contact Lens Services and Evaluation Fees

The charge for evaluating and determining your suitability for contact lens wear ***is not included*** in the comprehensive eye exam fee. A comprehensive eye exam must be performed prior to the contact lens exam.

A contact lens prescription renewal evaluation can be provided for current wearers during the comprehensive exam visit. We will verify the fit, comfort and check visual acuity. We will renew or make changes during the visit and the prescription will be valid for a year unless your physician prescribes otherwise. The service fee is ***$15.00*** and is collected at the time of service.

The evaluation fee is a professional service that does not include the cost of the lenses. Contact lenses are considered **elective vision correction** and most medical insurances will not cover elective services.

Nashville Vision Associates New Patient Registration **Chart # _____**

PATIENT INFORMATION		
Circle how were you referred to our office	**Internet/YP** **Patient** **Referring Physician/Other:**	
Patient Name	**Last** **First** **MI**	
Street or PO Box		
City State Zipcode		
Home Phone		**Cell phone**
Work Phone		**Employer**
Occupation		**Are you retired yes no**
Birth Date	**/ /**	**Sex Male Female**
Age		**Marital Status** Married/Spouse's Name:
Social Security #	- -	Single Divorced Widowed
Email address	***This may be used for contact lens orders or appointment confirmation.***	
Emergency Contact Name		
Emergency Contact Phone		
Primary Care Physician	**PCP phone**	
RESPONSIBLE PARTY	**(if not same as patient)**	
Name	**Last** **First** **MI**	
Address	**Street** **City** **State** **Zipcode**	
HEALTH INSURANCE *Primary Insurance Name:*	**Drs. Scott & Taylor** **DO NOT participate with EYEMED or any VISION plans**	
Insured Name (if not patient)		**Insured Birth Date (if not patient)**
Isured ID and Group #		
Patient's Relationship to the Insured Circle **Spouse or Dependent**		
Secondary Insurance Name:		
Insured Name (if not patient)		**Insured Birth Date (if not patient)**
Isured ID and Group #		
Patient's Relationship to the Insured Circle **Spouse or Dependent**		

By signing below I certify that I have read and completed this entire form truthfully and accurately. I understand that I am responsible for payment of all services rendered regardless of insurance and it is my responsibility to give NVA accurate insurance coverage information. NVA is not responsible for remittance of any policy information that is not in effect at the time of service. Payment for services due may include but are not limited to refraction, contact lens fittings, co-pays, and deductibles. I also authorize the release of any medical information necessary to process all claims and release payment to my physician. It is my responsibility to notify *NVA* of any changes to this information.

_____ _____ Office use only

Patient Signature or Legal Guardian if patient under 18 **Date** **Update by: _____**

MEDICAL HISTORY QUESTIONNAIRE ✍ **Please complete front and back ➔➔➔➔**

Name: _____ Date: _____
Primary Care Physician: _____ Date of birth: _____
Cardiologist: _____ Pharmacy: _____
Endocrinologist: _____ Pharm. Phone: _____
Rheumatologist: _____ **(please circle)**
Occupation: _____ Retired Married Single Widowed

Please CIRCLE all that apply to you in each section

Patient's past / present eye history: NONE

Cataract	Eye injections	LASIK or PRK	Eye surgery:_____
Cataract surgery	Flashes Floaters	Macular degeneration	
Contact lenses	Glaucoma	Muscle problems	_____
Crossed eyes	Glasses	Ocular migraines	
Diabetic retinopathy	High eye pressure	Red eyes	Other: _____
Double vision	Infection	Retina problems	
Dry eye	Injury:_____	Styes	_____
Droopy eyelids	Lazy eye (amblyopia)	Thyroid eye problems	

Past and present medical history: or None-good health

Alzheimer's	Cholesterol	Headache	Prostate medication use
Anxiety	COPD	High blood pressure	Stroke
Asthma	Dementia	Kidney disease	Thyroid problems
Auto immune	Depression	MRSA staph infection	Vascular disease
disease:_____	Diabetes	Mental Illness	Other:_____
Breathing problem	Heart problem:	Neuropathy	_____
Cancer:_____	bypass defibrillator	Parkinson's	_____
	pacemaker stent	Plaquenil use	

List major surgeries:_____

Do you smoke?☐Yes ☐No Do you drink alcohol?☐yes ☐No Do you use illegal drugs?☐Yes ☐ No
How much?_____ How much?_____ Explain: _____

Family History of eye disease (and who? Sister mother,etc.) **Family history of health problems: None**

Blindness	_____	Glaucoma	_____	Cancer	_____	Heart disease	_____
Cornea problem	_____	Macular degeneration	_____	Diabetes	_____	Other:	_____
Crossed eye	_____	Retinal detachment	_____	Stroke	_____		

Review of Systems: Are you presently having any of these problems? CIRCLE all that apply-

Eyes – vision decrease pain floaters flashes
General-weight loss or gain fever chills
Head- headache head injury dizziness
Nose- sinus pain nosebleeds hay fever
Neck- pain stiffness swollen glands
Respiratory- cough shortness of breath wheezing
Gastrointestinal- change in bowel habits bleeding
Musculoskeletal- joint / muscle pain swelling joints
Hematologic- bruise easily bleed easily
Psychiatric- nervous depression memory loss stress
Kidney, bladder- painful / frequent urination
Skin- color changes lumps rashes
Ears- decreased hearing ringing drainage
Throat- hoarseness difficulty swallowing loss of taste
Breasts- pain discharge lumps
Cardiovascular- swelling of extremities chest pain
Vascular- leg cramps calf pain with walking
Neurologic- seizures tremor weakness numbness dizziness
Endocrine- heat /cold intolerance frequent urination thirst
Allergy- hives food allergy seasonal allergies

Office use only:

History reviewed	Date:_____	☐ No change	☐ Additions as noted	Tech: _____	M.D. _____
History reviewed	Date:_____	☐ No change	☐ Additions as noted	Tech: _____	M.D. _____
History reviewed	Date:_____	☐ No change	☐ Additions as noted	Tech: _____	M.D. _____

MEDICATION LIST: (We can make a copy of your list)

Date updated:_____
Date updated:_____
Date updated:_____
Date

Name:_____

❋Please check ***none*** if there are none❋
updated:_____

Eye drops, ointments strength or % ❑ *None*	**Reasons you use** Such as glaucoma, dry eye, Infection, irritation, etc.	**Time of day you use**

Drug allergies ❑ *None*	**Type of reaction**	**Drug or other sensitivities**	**Type of reaction**

Prescription medications ❑ *None*	**Start Date**	**Dosage**	**What do you take it for?** ***Such as Diabetes, hypertension, etc***

Over the counter, vitamins etc.	❑ *None*

Nashville Vision Associates (NVA) Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____ Date of Birth_____

Consent for Treatment

_____ (Patient Initials) I, the undersigned, hereby consent to the following: administration and performance of general treatments, use of prescribed medications, performance of diagnostic procedures/test and cultures, based on the judgment of my physician or their assigned designees. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. A photocopy of this consent shall be considered as valid as the original.

I understand that I am responsible for all copayments, coinsurance, deductible and other fees such as refraction that are not covered by my insurance company and that *NVA* files my insurance claims as a courtesy. I also understand that I may be assessed a fee for missing my appointment or cancelling my appointment with less than a 24 hour notice.

_____ (Patient Initials) Notice of Privacy Practices. I acknowledge that *I have received* the practice's Summary of Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand a copy of the *Full Notice of Privacy Practices* is available upon request. I understand that I may contact the Privacy Officer designated on the notice in writing if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient Initials) Release of Information. I hereby permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physicians progress notes, nurse's notes, consultations in the office or hospital.

Disclosures to Friends and/or Family

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship to Patient	Contact Number

1. _____
2. _____
3. _____

Consent for Text usage for Appointment Reminders:

_____ (Patient Initials) I consent to receive text message from the practice to my cell phone and any number forwarded or transferred to that number for the purpose of my appointment reminder. I understand that this request to receive text message reminders will apply to all future appointment reminders unless I request a change in writing (see revocation section below). I authorize **this cell phone number** _____-_____-_____ to be used to send me appointment reminders.

**NVA does not charge to text reminders, but standard rates may apply based on your individual wireless plan. Contact your carrier for details.*

You must follow these instructions to set up text messaging:

1. Go to your messaging app on your phone
2. In the "To" area, type "**622622**"
3. In the "Message" area type the word "**Eyeballs**"
4. Hit send
5. You will receive a confirmation text back to let you know your service has been set up.

- ❖ If you get an error message, either your phone or your carrier has an issue with these types of messaging services. Contact your customer service department with your carrier for help.

Consent to Email for Contact Lens ordering or providing general health information:

_____ (Patient Initials) I authorize this email _____ to be used for contact lens ordering or providing general health information at the discretion of the *NVA*.

Patient/Patient Representative) Signature _____ Date _____

If at any time you wish to revoke your consent to receive text or email appointment reminders or other general information, you must do so in writing by including the date and time of request.

March 1, 2016

Nashville Vision Associates, PLC

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is a condensed version of our Full Notice of Privacy Practices. *Our full-length Notice is available upon request and on our website at nashvillevision.com* .

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS YOUR INFORMATION.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

Here are a few examples of how we use and disclose your information:

- For medical treatment, including referring you to another health care provider
- To obtain payment for our services
- In emergency situations
- For appointment and recall reminders
- For worker's compensation programs
- To avert a serious threat to public health or safety
- In response to requests arising from lawsuits
- Via fax, telephone, mail, email, or other approved secure methods

You have certain rights regarding the information we maintain about you. These include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice

For more information about these rights, please see the detailed Notice of Privacy Practices.

If you feel that your privacy rights have been violated, you may submit a complaint in writing to the Practice Manager. You will not be penalized for filing a complaint.

Effective Date: April 15, 2003
Last revision date: July 14, 2010