NASHVILLE VISION ASSOCIATES

Inez B. Bounds, M.D. · Frank H. Scott, M.D. · Rebecca J. Taylor, M.D.

WELCOME TO OUR PRACTICE

Thank you for choosing our practice to participate in your eye care needs. Drs. Bounds, Scott, Taylor and staff look forward to serving you!

We are enclosing your New Patient Forms. Please fill out all forms **completely** and bring them with you to your appointment. Completed forms will expedite your check in process and help us provide the most comprehensive medical care. Also bring the following:

- **Insurance Cards** including a **referral authorization** for a specialist if required. Please have your primary care physician fax it to us at **615.915.5074** prior to your appointment. Without a referral, your visit is not billable to insurance and all charges will be considered self pay due at the time of service or be rescheduled. (This includes but is not limited to HealthSpring, Cigna Connect and other HMO's)
- **Photo ID**
- **List of medications**
- **Glasses or contact lenses** you have been wearing

Please allow 1 to 1 ½ hours for your examination.

Can't make it? Call us!

We have reserved a time and prepared for your visit. We would appreciate the opportunity to give that time to another patient if this appointment no longer meets your needs. As of August 1, 2018 our office will require 24 hours' notice for cancellations or there will be a **$25 fee**. This fee will be assessed to patients who do not show for the scheduled appointment also.

Medical/Vision Plans

We are a medical/surgical practice that accepts assignment from Medicare and many other plans. It is the patient's responsibility to verify coverage prior to an appointment. Coverage does not guarantee payment of all claims.

We participate with these vision plans: EYEMED and VISION BLUE. Proof of coverage must be presented at check in. We may be able to file your vision claim as a courtesy to you if your visit is non-medical.

Please visit our website at **www.nashvillevision.com** for more information about our providers, locations, services and frequently asked questions.

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 that determines the best visual acuity and function of your eyes, which is essential medical information for us to assess your eye health. 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 ***$40.00*** and is collected at the time of service. Should your insurance pay for this service we will reimburse you.

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 medical exam fee. A comprehensive eye exam must be performed prior to a 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 to your lens type/power 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 medical insurances will not cover elective services.

Effective 8/1/2018

Nashville Vision Associates New Patient Registration **Date _____**

CHART # _____

PATIENT INFORMATION		
Circle how you were referred to us:	**Internet/Website** **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	**Relationship to contact**	
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:***	**Do you have a VISION plan? Yes or No**	
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**		

****KINDLY GIVE 24 HOURS' NOTICE TO AVOID A $25 MISSED APPOINTMENT FEE.**

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

Please complete ALL medications below or provide a meds list

Name:_____ Date of Birth:_____ Date:_____

DRUG ALLERGY ❑ *None*	**Type of reaction**	**DRUG ALLERGY**	**Type of reaction**

PRESCRIPTION MEDICATIONS ❑ *None*	**Dosage**	**Reason for use**

OVER-THE-COUNTER MEDICATION (Please include Aspirin & NSAID's) ❑ *None*	

EYE DROPS, OINTMENTS ❑ *None*	**Reason for use**	**Time of day you use**

List updated on:_____

PATIENT FINANCIAL RESPONSIBILITIES

I, the undersigned, in consideration for services being rendered to the patient *by NASHVILLE VISION ASSOCIATES, PLC* understand and agree to the following:

1.) I understand that payment for known deductibles, co-payments and any other noncovered charges are due on the date of service. If I cannot or will not pay at the time of service, the practice reserves the right to refuse treatment or to reschedule my appointment.
2.) I hereby authorize *NASHVILLE VISION ASSOCIATES, PLC* to file with my insurance carrier and I assign payment of medical benefits to *NASHVILLE VISION ASSOCIATES, PLC.*
3.) I will keep my account current as to charges for which I am responsible. If I fail to pay such charges, *NASHVILLE VISION ASSOCIATES, PLC* is entitled to take whatever necessary action is required to collect such balances.
4.) I understand that my insurance benefits and referral requirements are my responsibility. ***It is my responsibility to obtain my referral PRIOR to my appointment***. I understand that benefits can vary widely with any given carrier and that *NASHVILLE VISION ASSOCIATES, PLC* does not have knowledge of each individual policy holder's plan/coverages.
5.) I authorize release of any and all medical records and/or information necessary to *NASHVILLE VISION ASSOCIATES, PLC* for continuation of care and processing claims for services.
6.) I will inform *NASHVILLE VISION ASSOCIATES, PLC* of any change in personal information such as name, address, telephone numbers and insurance coverage.
7.) We will file your insurance claim as a courtesy. If you do not have your current insurance information on the date of service, your account will be self pay.
8.) I will make a reasonable effort to notify *NASHVILLE VISION ASSOCIATES, PLC* with a 24 hour notice if I cannot make my scheduled appointment. I understand that a $25 fee may be incurred if proper notice is not given.

My signature below indicates that I wish to agree to the terms above and receive medical care.

NASHVILLE VISION ASSOCIATES, PLC is not obligated to administer care without agreement to these terms. Your signature indicates agreement to all policies listed above for the duration of services.

_____ _____

Patient or Responsible Party Signature Date

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 in person 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 including correctional facilities
- To meet requirements of military command authorities both domestic and foreign
- In response to requests arising from lawsuits, audits, investigations required by government or national security
- To coroners, medical examiners or funeral directors to carry out their duties
- For appointment reminders 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 confidential communication for requests in writing
- 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, 4306 Harding Pike, Nashville, TN 37205. You will not be penalized for filing a complaint.

Effective Date: April 15, 2003
Last revision date: March 8, 2018

Name _____ MR#_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the *Summary of Privacy Practices* for Nashville Vision Associates. I understand that I may have a copy of the Full Notice of Privacy Practices if I request it.

_____ _____

Signature of Patient or Patient Representative (guardian) Date

We release personal health information about our patients when we are required to do so by federal, state or local laws and for a number of public policy reasons including public health reporting, law enforcement activities, judicial proceedings, workers' compensation, and certain types of records-based research. Whenever we release records for these reasons, we follow privacy safeguards appropriate to the situation.

If we need to use or disclose your records for purposes other than those described above, we will get a written authorization from you. You should know that you may revoke any authorization you give us at any time, but it must be in writing.

Authorization to Release Medical Information to Others

***In addition to myself, Nashville Vision Associates* may discuss my office visits, surgical care, test results or other documentation regarding my care or bill with those listed below:**

1. _____ relationship to patient _____
2. _____ relationship to patient _____
3. _____ relationship to patient _____
4. _____ relationship to patient _____

Patient's Name _____ Date _____ Chart # _____

THIS FORM IS OPTIONAL

Nashville Vision Associates, PLC

CONSENT TO TEXT APPOINTMENT REMINDERS

I consent to receive text messages from Nashville Vision Associates to my cell phone and any number forwarded or transferred to that number in regards to my *appointment* information. I understand that I will be given the option to text a response back before 11:00 pm to indicate my intent to keep or cancel that appointment. I understand this information will apply to all future appointments unless I request a change in writing.

- **The *cell phone number* I authorize to be used is (_____) _____.**

Follow these instructions on your phone 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.

MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE WILL INCUR A $25 FEE.

- **The *email* that I authorize to receive messages for contact lens order information and general health reminders/information is: _____.**

_____ _____

Signature of Patient or Patient Representative (guardian) Date