NASHVILLE VISION ASSOCIATES

James F. Conrad, M.D. **Michael J. Dieckhaus, M.D.**

Jordan L. Herring, M.D. **Frank H. Scott, M.D.** **Rebecca J. Taylor, M.D.**

Phone: 615.297.6591 *Fax:* 615.915.5091

WELCOME TO OUR PRACTICE

Thank you for choosing our practice to participate in your eye care needs.
Drs. Conrad, Dieckhaus, Herring, 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 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**
- **Prescription glasses or over the counter readers**
- **Wear your contact lenses and bring the current prescription (ex: photo of box(s))**
- 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. Please give 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.

Medical/Vision Plans

We are a medical/surgical practice that accepts assignment from Medicare and many other **medical** plans, but **not VISION** plans. It is the patient's responsibility to verify coverage prior to an appointment. Coverage does not guarantee payment of all claims. You are responsible for all non-covered services.

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

Nashville Vision Associates New Patient Registration

PATIENT INFORMATION			
Circle how you were referred to us:	**Internet/Website**	**Patient**	**Referring Physician/Other**
Patient Name	Last	First	MI
Patient Address	Street or PO Box		
	City	State	Zipcode
Home Phone		**Cell phone**	
Email address	***This may be used for contact lens orders or appointment confirmation.***		
Preferred Contact Method	(circle one) Home Phone	Cell Phone	Email
Work Phone		**Employer**	
Occupation		**Are you retired** **yes** **no**	
Birth Date	/ /	**Sex** **Male** **Female**	
Age		Circle: Fiance Married Partnered	
Social Security #	- -	Single Divorced Widowed Nondeclared	
Emergency Contact Name	**Relationship to patient:**		
Emergency Contact Phone			
Primary Care Physician	**PCP phone**		
RESPONSIBLE PARTY	**(if not same as patient)**		
Name	**Last**	**First**	**MI**
Address	**Street**	**City** **State**	**Zipcode**
MEDICAL INSURANCE ***Primary Insurance Name:***			
Insured Name (if not patient)	**Insured Birth Date (if not patient)**		
Inured ID and Group #			
Patient's Relationship to the Insured	**Circle: Spouse Partner or Dependent**		
Secondary Insurance Name:			
Insured Name (if not patient)	**Insured Birth Date (if not patient)**		
Insured ID and Group #			
Patient's Relationship to the Insured	**Circle: Spouse Partner or Dependent**		

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

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 the 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

_____ **Initialing here indicates that I received a *Summary of Privacy Practices***

I authorize the following, in addition to myself, to discuss my medical care or financial account:

1. _____ **relationship to patient** _____

2. _____ **relationship to patient** _____

3. _____ **relationship to patient** _____

OR

Initial here _____ if you do not wish to authorize anyone else to have access to my records as stated above.

Patient Signature _____ **Date** _____

For more information about these rights, please request 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, 4515 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

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 ***$50.00*** 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 to conclude the eyes are healthy for wearing lenses in them.

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. New wearers will be fitted at a different appointment with one of our professional contact lens staff. A summary of expectations and fees is given after the exam.

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 do not cover elective services.

Effective 1/2023

PATIENT FINANCIAL RESPONSIBILITIES

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 the 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 policyholder's plan/coverages.

5.) I authorize the release of any and all medical records and/or information necessary to *NASHVILLE VISION ASSOCIATES, PLC* for the 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.

Patient Name _____ Patient DOB _____

By signing my name below, I agree to the financial terms including policies regarding contact lens fitting and refraction fees. I also give consent to receive medical care.

Patient or Responsible Party Signature _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE

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

MEDICATION LIST

Please complete ALL medications below or provide a meds list

Name:_____ Date of Birth:_____ Date:_____

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

PRESCRIPTION MEDICATIONS	Dosage	Reason for use
❑ *None*		

Do you take Aspirin or NSAID's (Ibuprofen, Aleve, Celebrex, Motrin)? ☐ NO ☐ YES
If yes, list below.

OVER-THE-COUNTER MEDICATION	
❑ *None*	

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