

The Eye Center

OF OAK RIDGE, P.C.

Total eye care.

90 Vermont Avenue
Oak Ridge, TN 37830-5225
865-482-8890
fax 865-482-7400

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Ocular Pathology
Diplomate
American Board of Ophthalmology
Fellow
American Academy of Ophthalmology
Member
American Association of
Ophthalmic Pathologists

Bradley J. Luttrell, M.D.
Diplomate
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American Academy of Ophthalmology

Eric E. Speckner, M.D.
Diplomate
American Board of Ophthalmology
Fellow
American Academy of Ophthalmology
Member
American Glaucoma Society

Optometry - Contact Lenses

James E. Kuneman, O.D.
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American Optometric Association

Paul W. Tappan, O.D.
Member
American Optometric Association

Jackie L. Greene, O.D.
Member
American Optometric Association

Thomas L. Gunter, O.D.
Member
American Optometric Association

Scott L. Baer, O.D.
Member
American Optometric Association

Natalie L. Frasier, O.D.
Member
American Optometric Association

Heather R. Walker, O.D.
Member
American Optometric Association

Danny W. Cross, O.D.
Member
American Optometric Association

Practice Administrator

Kim Southmayd
Certified Ophthalmic Executive

Thank you for entrusting us with your vision care. We look forward to serving you in a caring, efficient and professional manner.

During your first visit it will be necessary to create your medical record. We would appreciate your assistance in expediting this process. Please complete and review ALL of the enclosed forms (front and back when necessary). By completing this step in advance, we can better focus on meeting your eye care needs during your visit.

We respectfully request that you **ARRIVE FIFTEEN MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.** This will allow us to verify your information and enter it into our computer system prior to your appointment time with the doctor.

PLEASE BRING WITH YOU TO YOUR APPOINTMENT THE FOLLOWING:

- **COMPLETED FORMS-** Patient / Insurance Information (front and back), Eye Patient Health History, and Notice of Non-Covered Services.
- **BOTH HEALTH AND EYE INSURANCE CARDS**
- **PAYMENT** for co-pays, deductible, co-insurance amount and any services not covered by your insurance. We accept cash, checks and most major credit cards. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**
- **REFERRAL-** if your insurance requires it, otherwise payment is expected at the time of service.

We are very pleased that you have chosen us for your eye care. Feel free to call our office if we can be of assistance to you in completing this paperwork or with any other questions you might have about you appointment.

We look forward to seeing you!

Kim Southmayd
Practice Administrator

MIDTOWN
1855 Tanner Way, Suite 120
Harriman, TN 37748
865-882-1535
fax 865-882-9497

LENOIR CITY
603 Highway 321 N, Suite 301
Lenoir City, TN 37771-6541
865-986-3518
fax 865-986-6380

WARTBURG
950 Main Street, Suite C
Wartburg, TN 37887
423-346-1855
fax 423-346-1890

ONEIDA
18730 Alberta St.
Oneida, TN 37841
423-569-6822
fax 423-569-6833

1-888-328-2020
toll free

Welcome to The Eye Center of Oak Ridge

Doctor: _____

We would appreciate your help in answering the following questions:

How did you hear about our practice?

Our Web-site (www.theeyecenters.net)

Referred by another doctor.

If referred, please provide the name of the doctor. _____

Referred by my insurance company.

If referred, please provide the name of your insurance company. _____

Family member/ friend.

Yellow pages.

Google search.

Other Internet search engine.

Please identify the search engine. _____

Facebook

Other

Please specify. _____

Did you know that one of our Eye Center surgeons, Dr Tommy Dahl, is now performing LASIK?

Yes No

PATIENT INFORMATION

Patient's Last Name _____ First _____ MI _____

(Please Print)

Preferred Name _____

Social Security # _____ Age _____ Sex _____ Race _____ Birthdate _____

Address _____ Marital Status: M S D W

City _____ State _____ Zip _____

Cell Phone# _____ Home Phone# _____ Work Phone# _____

May we leave detailed personal health information on your contact phone number voicemail?

This information may include pathology results, lab results, appointments, etc.

Home Phone: Yes No Cell Phone: Yes No Business Phone: Yes No

Who may we discuss your health information with?

No one other than self Spouse Parent Voicemail Other _____

Name and Address of Employer _____

Name of Spouse or Parent/Guardian _____

(if patient is under 18 yrs of age)

Spouse Work Phone# _____ Spouse Cell Phone# _____

Family Doctor _____ Name of Clinic _____

Emergency Contact _____ Relationship _____ Phone# _____

(Friend or Relative not living with you)

I HEREBY ACKNOWLEDGE HAVING READ OR RECEIVED THE NOTICE OF INFORMATION PRACTICES.

I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER WHO ACCEPTS ASSIGNMENT. I UNDERSTAND ANY COPAYS AND NON-COVERED SERVICES ARE TO BE PAID AT THE TIME OF SERVICE.

I WILL NOTIFY THE EYE CENTER WITHIN 24 HOURS OF MY APPOINTMENT IN THE EVENT THAT I AM UNABLE TO ATTEND; FAILURE TO DO SO MAY RESULT IN A \$30.00 CANCELLATION FEE.

Patient's Signature: _____ Date: _____

(Parent or Guardian if under 18)

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY # _____ GROUP # _____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

SECONDARY INSURANCE _____ POLICY # _____ GROUP # _____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

GUARANTOR _____ Guarantor DOB _____

(if different from patient or insured)

Guarantor Name _____ Guarantor DOB _____

Guarantor Address _____ Guarantor SS# _____

Guarantor Cell Ph# _____ Guarantor Home Ph# _____ Guarantor Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

EYE PATIENT HEALTH HISTORY

Patient's Last Name _____ First _____ MI _____ Preferred Name _____

Race _____ Date of Birth _____ Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Name of referring physician _____

Are you taking any kind of MEDICATION now? (This includes prescription, over-the-counter or herbal medications)
 No Yes If yes, please list below.

NAME, DOSE and HOW OFTEN	Problem being treated	Date of Prescription	Prescribing Doctor

Are you ALLERGIC to any medication? No Yes If yes, please list below.

Name of Medication	Type of Reaction

PAST MEDICAL HISTORY

Have you ever been diagnosed with a major health problem? (Ex. diabetes, asthma, glaucoma) No Yes (List)

Have you ever had a serious EYE INJURY or SURGERY ON YOUR EYES? No Yes (List)

FAMILY HISTORY

Are there any EYE PROBLEMS that seem to run in your family such as glaucoma No Yes (List)

SOCIAL HISTORY

What is or was your occupation? _____ Check here if you are retired. Marital Status _____

Do you currently smoke? No Yes

Living setting: Alone Spouse Children Mother Father Nursing Home Assisted living other _____

REVIEW OF SYSTEMS List any problems you have or have had recently in the following areas.

General Health: (fever, weight loss or gain, problems sleeping, fatigue, weakness, etc.) No Yes

Eyes: problems that have not been corrected by glasses (visual loss, double vision, blurred vision, etc.) No Yes

The Eye Center of Oak Ridge Financial Policy

1. **INSURANCE** We participate in most primary insurance plans, including Medicare. We will also file any secondary insurance as a courtesy. *Knowing and understanding YOUR insurance benefits is YOUR responsibility.* If you are not insured by a plan we are in contract with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but do not have an up to date insurance card, payment in full is expected.
 2. **CO-PAYMENTS AND DEDUCTIBLES** All co-payments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.
 3. **CO-INSURANCE** After your insurance processes the claims, you will be billed for any co-insurance or patient responsibility according to your insurance contract.
 4. **REFERRALS** Some insurers require referrals for services. It is YOUR responsibility to obtain referrals. If you did not obtain a referral prior to services, you will be responsible for the balance.
 5. **CLAIMS SUBMISSION** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. **IT IS YOUR RESPONSIBILITY TO COMPLY WITH THEIR REQUEST.** Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not a party to that contract.
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6. **NON-PAYMENT** If your account is over 90 days past due, we will turn your account over to our collection agency.
 7. **NON-COVERED SERVICES** Please be aware that some and perhaps all of the services you receive may be non-covered or considered not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit. Initial
- Example: **REFRACTION FEE \$40.00 (Measurement to check how well you can see.)**

Please sign below to indicate that you have read and you fully understand our Financial Policy.

Patient Name (Please print)

Patient or Guarantor Signature

Date