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

Robert E. Walker, M.D.
Diplomate
American Board of Ophthalmology
Fellow
American Academy of Ophthalmology

Timothy P. Powers, M.D.
Ocular Pathology
Diplomate
American Board of Ophthalmology
Fellow
American Academy of Ophthalmology
Member
American Association of Ophthalmic Pathologists

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

Kathryn R. Baker, M.D.
Diplomate
American Board of Ophthalmology
Fellow
American Academy of Ophthalmology

Thomas L. Dahl, M.D.
Diplomate
American Board of Ophthalmology
Fellow
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.
Member
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 the enclosed Patient Information / Insurance Information (two-sided), Eye Patient Health History and Notice of Non-Covered Services forms. By completing this step in advance we can better focus on meeting your eye care needs during your visit.

We have also enclosed a copy of our Notice of Privacy practices for your review.

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 visit with the doctor.

Please plan to 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.

- **Your insurance card.**

- **Payment for co-pays, deductibles, co-insurance amount and any services not covered by your insurance**. We accept cash, checks and 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 your appointment.

We look forward to seeing you!

Kim Southmayd
Practice Administrator

1-888-328-2020 toll free

MIDTOWN
1855 Tanner Way, Suite 120
Harriman, TN 37748

LENOIR CITY
603 Highway 321 N, Suite 301
Lenoir City, TN 37771-6541

WARTBURG
950 Main Street, Suite C
Wartburg, TN 37887

ONEIDA
18730 Alberta St.
Oneida, TN 37841

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 CANCELATION 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, ovcr-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, P.C.

Notice of Non-Covered Services

REFRACTION **(Measurement to check how well you can see)**

As part of your examination, it may be necessary for us to measure how well you can see. This test is called a **"refraction"**. In some situations, it will be necessary for us to perform this measurement to fully evaluate your eye condition, even if you do not desire new glasses.

Some insurance companies **will not** pay for services they consider to be non-covered services. You will be responsible for such services if your insurance considers it non-covered.

REFRACTION FEE: $35.00

Signature: ______________________________ Date: ____________________
Patient or Parent/Legal Guardian

O.C.T (Optical Coherence Tomography)

As part of your examination, it may be necessary for us to perform an O.C.T scan.
Optical coherence tomography (OCT) is a non-invasive imaging test which uses light waves to take cross-section pictures of your retina.

With OCT, your doctor can see each of the retina's distinctive layers. This allows us to map and measure their thickness to detect disease and possible drug therapy toxicity. These measurements also help provide treatment guidance for glaucoma and diseases of the retina.

Some insurance companies **will not** pay for services they consider to be non-covered services. You will be responsible for such services if your insurance considers it non-covered.

O.C.T. FEE: $50.00

We will be happy to answer any questions you may have.

Signature: ______________________________ Date: ____________________
Patient or Parent/Legal Guardian

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. ***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.

   Example: ***REFRACTION FEE $35.00 (Measurement to check how well you can see.)***
5. ***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.
6. ***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.
7. ***NON-PAYMENT*** If your account is over 90 days past due, we will turn your account over to our collection agency.

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