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

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

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, 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, 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.

Medicare and most other insurance companies **will not** pay for services they consider to be non-covered services. You will be responsible for such services at the time of your examination.

REFRACTION FEE: $35.00

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

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Signature: _____ Date: _____
Patient or Parent/Legal Guardian

Patient Rights and Responsibilities

As a patient of The Eye Surgery Center of Oak Ridge, you can expect to be treated individually and with the respect you deserve. You have the right to:

- Receive treatment without discrimination as to sex, race, religion, national origin or disability.
- Receive respectful and considerate care in a clean and safe environment.
- Participate in all decisions regarding your care.
- Receive private, confidential care of all information regarding your health & the records of your care.
- Approve or refuse the release of your medical records except when required by law.
- Know fees for service and the billing process.
- Refuse treatment and receive information on how your refusal can affect your health.
- Complain without fear of retribution about the care and service you receive.
- Assure safe use of equipment by trained personnel.
- Change primary or specialty physicians if you so choose.
- Receive assessment for pain by trained personnel and to have that pain treated efficiently.

In turn, as a patient of The Eye Surgery Center of Oak Ridge, it is your responsibility to:

- Provide accurate, detailed medical histories, complaints, illnesses, hospitalizations and surgeries.
- Provide a list of current medications, allergies etc.
- Inform the staff of your advance directives/living will.
- Assure your financial obligations to the center for healthcare services rendered are paid efficiently.
- Accept responsibility for your actions if you refuse a treatment or procedure.
- Accept responsibility for your actions if you do not follow or understand the instruction given by the physician or staff.
- Keep your appointments or notify the center if you anticipate that your treatment will be delayed.
- Ensure the security of your own valuables.
- Follow the treatment plan provided by the physician.
- Be respectful of staff.

You have the right to disclosure of ownership of The Eye Surgery Center of Oak Ridge:

- The following physicians do have a financial interest in this facility:
  Dr. Robert Walker, Dr. Tim Powers, Dr. Brad Luttrell, Dr. Kathryn Baker and Dr. Thomas Dahl
- The following physician does not have a financial interest in this facility:
  Dr. Eric Speckner

Complaints or grievances may be lodged to:

- The Practice Administrator or Director of Nursing

- East Tennessee Department of Health Care Facilities
  425 5th Avenue North, Cordell Hull Bldg. 3rd Floor
  Nashville, TN 37243
  (800) 852-2187
  State ID: TN P53578

You may also contact AAAHC by mail at:

- Accreditation Association for Ambulatory Health Care, Inc.
  5250 Old Orchard Road, Suite 200
  Skokie, Illinois 60077

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at:

- www.cms.hhs.gov/center/ombudsman