McCabe Vision Center

State-of-the-Art Care by State-of-the-Heart People

Date: ____/____/_____

Welcome and thank you for choosing McCabe Vision Center for your eye care needs. We take pride in providing you with the best vision correction possible.

Name: ____
(Last) (First) (M.I.) (Nick Name)

Address: ____________________________________ City: ______________________State: _____ Zip: _________

Home Phone: (_____)__________-___________ Cell Phone: (_____)_____-__________

Employer: ______________________________ Work Phone: (_____) _____-_________

Date of Birth: ______/______/______ (Age :____) Sex: □ Male □ Female

Social Security Number: ______-______-______ Driver's License#: ________________________

Email Address: ____

Spouse's Name: ______________________________________

Spouse's S.S.N :______-______-_________ Spouse's Date of Birth: _____/_____/_______

Emergency Contact: __________________________ Best Phone Number: (____)_____-_________

Family Physician: ____________________________ Phone Number: (____)______-____________

Referring Physician: __________________________ Phone Number: (____)______-____________

If you were not referred by a physician, who may we thank for referring you or how did you hear about McCabe Vision Center? ____

If a Minor (< 18 yrs old)

Guarantor Name: ____ Date of Birth: _______/_____/________

Address: ____ City: ____________________ State: ______ Zip: _________

Daytime Phone Number: (_____) ______-_______ Evening Phone Number: (____) _______-_________

Driver's License Number: ____________________ Social Security Number: ______-______-_________

Medical and Vision Insurance Information or Workman's Comp. Claim

Primary Insurance: _________________________ ID Number: ____

Subscriber Name: __________________________ Subscriber Date of Birth: _____/______/______

Secondary Insurance: _______________________ ID Number: ____

Subscriber Name: __________________________ Subscriber Date of Birth: _____/_____/_______

Vision Insurance: __________________________

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Patient Name: ____ **Today's Date:** _____/____/________

Please tell us the reason for your visit today: ____

____

Do you have or do you see the following?

- ☐ Blurred Vision
- ☐ Burning
- ☐ Double Vision
- ☐ Dryness
- ☐ Fainting and/or dizziness
- ☐ Flashes of Light
- ☐ Floaters or spots
- ☐ Gritty Sensation
- ☐ Headaches
- ☐ Itching
- ☐ Nausea
- ☐ Night blindness/glare when night driving
- ☐ Eye Pain
- ☐ Red Eye
- ☐ Light Sensitivity
- ☐ Sudden Vision Loss
- ☐ Difficulty seeing street signs with glasses or contacts

Have you ever been diagnosed with:

- ☐ Arthritis
- ☐ Asthma
- ☐ Breathing Problems ☐
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Hay Fever
- ☐ Seasonal/Perennial Allergies
- ☐ Headaches/Migraines
- ☐ Tremors, Parkinson's
- ☐ Convulsions, Epilepsy
- ☐ High Blood Pressure for____yrs.
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Other Heart Problems
- ☐ Swelling Ankles
- ☐ Kidney Problems
- ☐ Thyroid Disorders
- ☐ Hepatitis, Liver Disease
- ☐ Cancer; Type______________
- ☐ Stroke
- ☐ Diabetes Mellitus
- ☐ Insulin and/or ☐ Pills
- ☐ High Cholesterol
- ☐ Pregnancy/Nursing
- ☐ HIV/AIDS
- ☐ Amblyopia
- ☐ Cataracts
- ☐ Color Blindness
- ☐ Crossed Eyes
- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Previous Eye Trauma
- ☐ Retinal Detachment
- ☐ Other____________________
- ☐ None of the Above

Please list all surgeries, including eye surgeries, you have had and dates:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________

Primary Care Physician's Name: ____

Prescription Insurance: ____

Name of your pharmacy: ______________________________ **Location:** _______________________

Please list all of your current medications, including over the counter medicines and vitamins:

Medication Name	Times/Day	For what problem?

Please list all eye drops you currently use:

Eye Drop Name	Times/Day	Which eye?

Medication Allergies: ____

What are your hobbies? ____

HIPPA Privacy Policy

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The Practice has a Notice of Privacy Policy and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ____

Signature of Patient or Representative

____

Printed Name of Patient or Representative

Relationship to Patient (if other than patient):_________________________ Date: _________

In front of ____

Printed Name of Practice Representative

CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION

TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE

Patient Name: ______________________________ Patient Date of Birth: __________________

Professional ethics require your signature and permission before we can release any information concerning your health records to anyone, including family members.

I hereby consent and agree that McCabe Vision Center may disclose my protected health information to a family member, relative, friend, physician or other individual that I identify below who is directly involved in my vision health care or the payment of my eye care.

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

I understand that this consent is effective immediately and shall remain in effect until I revoke it by providing written notice to McCabe Vision Center. I understand that revocation becomes effective upon receipt.

______________________________ ______________________
Patient Signature Today's Date

By signing the line below:
I DO **NOT** CONSENT OR GIVE PERMISSION TO THE RELEASE OF MY HEALTH RECORDS **TO ANYONE**

____
Patient Signature denying release of health records

Revised 01/14/14

122 HERITAGE PARK DRIVE
MURFREESBORO, TN 37129
PHONE: 615-904-9024
FAX: 615-904-0337

AUTHORIZATION TO REQUEST MEDICAL INFORMATION

To: ___________________________________ ***Fax:*** __________________________________

Phone: _______________________________ ***Pages:*** ________

Re: ____

Patient: ____ **Today's Date:** ___/___/____

Date of Birth: ______ /______ /_________

I hereby authorize McCabe Vision Center to request health information that is contained in my patient records from another physician to assist in my eye care. I understand and acknowledge that this may include treatment plans, any test results or diagnoses.

Signature: ____ **Today's Date:** ______________

I do **NOT** authorize McCabe Vision Center to request health information that is contained in my patient records from another physician. I understand and acknowledge that this may include treatment plans, test results or diagnoses.

Signature: ____ **Today's Date:** _______________

This communication constitutes an electronic communication within the meaning of the Electronic Communications Privacy Act, 19 USC 2510, and its disclosure is strictly limited to the recipient intended by the sender of this message. This communication may contain confidential and privileged material for the sole use of the intended recipient and the disclosure to anyone other than the intended recipient does not constitute a loss of the confidential or privileged nature of the communication. If you are not the intended recipient, please contact the sender by return electronic mail and delete all copies of this communication. McCabe Vision Center is not liable if an attachment is altered without its written consent. Thank you.

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FINANCIAL POLICIES & AGREEMENT

- **Payment for service is due at the time services are rendered:** This includes all copays and cash charges. We accept cash, personal checks, and all major credit cards.
- **The Refraction Fee:** The Refraction is a necessary part of any thorough eye exam that must be performed so that your Doctor knows your current maximum vision and eye health. The refraction is also required to obtain a prescription for glasses or contact lenses, or before any eye surgery. Unfortunately, most insurance companies do *not* cover this service unless you have special vision insurance. There is a $45.00 fee for this service; however, we will discount the cost to $35, if paid on the date of service.
- **For Patients Using Insurance:** Due to timely filing limits by insurance companies; you have *30 days* from the date service is rendered to provide our office with updated insurance information. If you do not provide us with your correct insurance information within *30 days*, you agree to be solely responsible for all charges. Also, your insurance may not cover all services (i.e, Contact Lens Fitting and supply, Glasses, Injections, Topography, Deluxe or Toric Lens Implants, LASIK, Corneal Relaxing Incisions, etc.).
    - **HMO Insurance:** *It is your responsibility to obtain a referral from your PCP prior to your appointment.* If you fail to obtain your referral, you may reschedule your appointment or you will be solely responsible for payment of all services rendered on that date.
    - **Worker's Compensation***: It is your responsibility to call your employer to get the visit authorized.* We will file your company's insurance. In the event you fail to report your injury to your employer or the condition is determined not to be the result of a Worker's Compensation case, you agree to pay all charges for services rendered.
- **For Patients Not Using Insurance:** If you are a ***self-pay new patient***, you will be asked to pay a $150.00 down payment before services are rendered. Any additional charges or refunds will be payable at check-out, unless other arrangements are made. If you are a ***self-pay patient of record,*** you are responsible for all charges incurred at the time of service. *We will discount Office Visits and Testing 20% if paid the day of service.* This discount *excludes*: Contact Lens Fitting and Supply, Glasses, Injections, Topography, Deluxe or Toric Lens Implants, LASIK and Corneal Relaxing Incisions, etc.
- **Unpaid balances after 90 days, including those that insurance has denied,** *will be assessed a 2% per month late fee and sent to collections*. You will be responsible for all collection fees. However, we realize emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account.
- **Need to cancel an appointment?** Kindly provide us with at least a 24 hour notice. If you do not, then a $25 missed appointment fee will be assessed.
- **Need your records or any other forms filled out by our office?** There will be a $25.00 charge for the first 25 pages and 25 cents per additional page for your records release. There is also a $25 charge for *any* form for any reason that requires the doctor's review and signature.

I have read, understand and agree to the McCabe Vision Center Financial Policy.

Signature: ____ **Date**: ________________