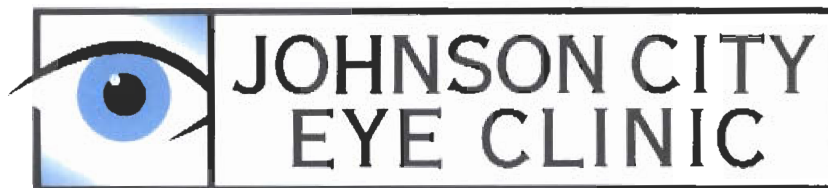


110 MED TECH PARKWAY, SUITE 1
JOHNSON CITY, TN 37604
(423) 929-2111

Welcome to our practice! An appointment has been scheduled for you at our office with:

Dr. ______________________________ on _______________ at ________

We hope that the following directions and request will be of help to you and assist our staff and physicians in your care. We respect your time and would like to make your visit as efficient as possible. Therefore we ask that you arrive fifteen minutes prior to your scheduled appointment to allow our front office time to complete the patient registration process.

Location

From I-26 take exit 19 to N. State of Franklin Rd. (381S). Travel Approximately 1 mile, turn left on Knob Creek Rd. (Bank of Tennessee on right). Proceed .1 mile to 4-way stop, turn right onto Med Tech Parkway. Johnson City Eye Clinic will be your second right.

Medical Information

Please complete the enclosed patient information sheet and patient history sheet. Please bring a current list of all your medications and copy of any records or testing that would be pertinent to your visit with our office. We would also like to make you aware that depending on the amount and nature of testing required it is possible that your visit could be as long as two to three hours. Therefore, if you are diabetic be certain that you have eaten before you arrive. Due to the possibility that your eyes may be dilated, you may need to arrange for transportation to and from your appointment. We understand that patients often are escorted to their appointments by more than one family member. However, due to the size of our sub-wait areas we ask that all but one family member remain in the main lobby. If you have an appointment with our contact lens technician please be certain that you wear your lenses to your appointment.

HIPPA

We are required by applicable federal and state laws to maintain the privacy of our patients and their medical information. Therefore we have enclosed a copy of our Privacy Notice for your review. Enclosed you will find a form Notice Receipt Acknowledgement. This form must be signed by you or your personal representative acknowledging that you have received a copy of our Privacy Notice. We have also enclosed a Release of Protected Health Information. Please list anyone on this form that you wish to designate to receive or change information pertaining to your appointments, prescriptions and/or account information. Please bring the signed Notice Receipt Acknowledgement and the completed Release of Protected Health Information to your appointment.

Fees and payment

We expect payment at the time of your appointment. If you are unable to pay the portion due you must make payment arrangements with our Insurance and Billing department prior to your visit.

Medical Insurance

Please bring your insurance card and any necessary referral that your insurance company may require to this appointment. If you are unable to bring your insurance information to the appointment please come prepared to pay in full and our office will provide an itemized statement for insurance purposes.

Cancellation

Please notify our office 24 hours in advance if you are unable to keep your scheduled appointment. Appointments not cancelled are disruptive to our practice and unfair to those waiting for appointments. Failure to cancel appointments that you are unable to keep may result in a no-show fee being charged. Patients who routinely miss appointments without cancellation cannot be retained in our practice.

We look forward to seeing you.

Sincerely,
Johnson City Eye Clinic

PATIENT HISTORY

NAME: ____________________ **DOB:** _________ **CHART#:**_________

Review Date/Signature	

Current Medications:

(Please list ALL medications including herbs, vitamins, and aspirin)

1. ______________ 2. ______________ 3. ______________
4. ______________ 5. ______________ 6. ______________
7. ______________ 8. ______________ 9. ______________
10. ______________ 11. ______________ 12. ______________
13. ______________ 14. ______________ 15. ______________

ALLEGIES TO ANY MEDICATIONS: ______________________________

____

SOCIAL HISTORY:

Do you smoke? Yes __ No __ Do you drink alcohol? Yes __ No __
Are you pregnant? Yes __ No __

REVIEW OF SYSTEMS and Past Medical History

Do you currently have any problems or have you had surgery for the following?

	Please Circle:
• Chronic fever, unexpected weight gain or loss, fatigue	YES NO
• Ear/Nose/Throat (i.e. hearing loss, sore throat, sinus, allergies)	YES NO
• Heart (i.e. chest pain, irregular heartbeat, congestive heart failure, heart attack, stroke)	YES NO
• Respiratory (i.e. shortness of breath, coughing, asthma, emphysema, chronic bronchitis, tuberculosis)	YES NO
• Gastrointestinal (i.e. heartburn, diarrhea, vomiting, hiatal hernia)	YES NO
• Hepatitis, diverticulitis, peptic ulcer, gallbladder trouble)	YES NO
• Urinary (i.e. pain, discomfort, blood in urine, kidney stones)	YES NO
• Skin conditions (i.e. rash, excessive dryness, allergies)	YES NO
• Musculoskeletal (i.e. swollen joints, joint pain)	YES NO
• Neurological (i.e. numbness, weakness, headache, paralysis)	YES NO
• Psychiatric (i.e. depression, anxiety, nervousness)	YES NO

List any Surgeries: ____

EYE HISTORY:

Do you wear glasses for any of the following? ___ Distance ___ Reading ___ Constant Wear
Do you wear contact lens? ___ Yes ___ No
If yes, please specify: ___ Soft Lens ___ Hard Lens ___ Gas Permeable

PERSONAL HISTORY:

- Retinal Detachment YES NO
- Macular Degeneration YES NO
- Cataracts YES NO
- Glaucoma YES NO
- Lazy Eye YES NO
- High Blood Pressure YES NO
- Heart Disease YES NO
- Diabetes YES NO
- Cancer YES NO
- Other: ______________________

FAMILY HISTORY:

- Retinal Detachment YES NO
- Macular Degeneration YES NO
- Cataracts YES NO
- Glaucoma YES NO
- Lazy Eye YES NO
- High Blood Pressure YES NO
- Heart Disease YES NO
- Diabetes YES NO
- Cancer YES NO
- Other: ______________________

Family Members with Bad Vision that can't be corrected with glasses? YES ____ NO ____

PEDIATRIC HISTORY:

Full term or Premature? __________ Weeks? __________

Birth Weight? __________

Has your child been diagnosed or treated for Retinopathy or Prematurity (i.e. ROP) YES ____ NO ____

Problems with Birth? Vaginal _____ C-Section _____

Why was C-Section Performed? ____

____

Problems with Pregnancy, Infection, Birth Defects? ________________________________

____

JOHNSON CITY EYE CLINIC

PATIENT INFORMATION SHEET

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST - FIRST - MIDDLE)	DATE OF BIRTH	AGE	MARITAL STATUS S ☐ M ☐	DATE
ADDRESS (STREET, CITY, STATE, ZIP)			HOME PHONE ( )	
CELL PHONE ( )		SOCIAL SECURITY NUMBER - -		
NAME OF EMPLOYER	OCCUPATION		WORK PHONE ( )	EXTENSION
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)				
SPOUSE'S NAME (LAST - FIRST - MIDDLE)	DATE OF BIRTH	NAME OF EMPLOYER	WORK PHONE ( )	
PARENT OR LEGAL GUARDIAN (FULL NAME)		SOCIAL SECURITY NUMBER - -		
ADDRESS (STREET, CITY, STATE, ZIP)				

EMERGENCY CONTACT

NAME	RELATION	PHONE NUMBER ( )

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN (NAME)	ADDRESS	PHONE NUMBER ( )
PRIMARY CARE PHYSICIAN (NAME)	ADDRESS	PHONE NUMBER ( )

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET, CITY)	PHONE NUMBER ( )
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATION TO PATIENT
EMPLOYER	POLICY OR I.D. NUMBER	GROUP NUMBER
SECONDARY INSURANCE NAME	ADDRESS (STREET, CITY, STATE, ZIP)	PHONE NUMBER ( )
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATION TO PATIENT
EMPLOYER	POLICY OR I.D. NUMBER	GROUP NUMBER

PLEASE COMPLETE FORM AND BRING WITH YOU AT THE TIME OF YOUR APPOINTMENT

Signature of File, Assignment of Benefits, Financial Agreement

110 MED TECH PARKWAY • SUITE 1
JOHNSON CITY, TENNESSEE 37604

FINANCIAL RESPONSIBILITY

I understand that all services rendered to ______________________________ are my financial responsibility and that payment is due at the time of treatment unless prior arrangement has been made. I accept full responsibility for the payment of any services not covered by my insurance carrier. I agree to pay collection fees, court cost, and attorney fees if legal actions are necessary for collection of this account.

RELEASE OF MEDICAL INFORMATION

Johnson City Eye Clinic may disclose all or any part of my medical record and/or Financial ledger, to my insurance companies, or my attorney if liability related, or Employer and their Workman's Compensation carrier if a job related injury.

MEDICARE

I agree that payment of authorized Medicare benefits be made either to me or on my behalf to Johnson City Eye Clinic, P.C. for any services furnished to me by their physicians. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the Medicare claims for services provided by the clinic physicians.

MEDIGAP

I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency show. I request that payment of authorized secondary insurance benefits be made on my behalf to Johnson City Eye Clinic.

OTHER INSURANCE

I hereby authorize Johnson City Eye Clinic, P.C. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Johnson City Eye Clinic, and direct my carrier or its intermediaries to issue payment directly to Johnson City Eye Clinic, P.C. I understand I am financially responsible to Johnson City Eye Clinic, P.C.

NON-COVERED SERVICES

I understand that Medicare, and most commercial insurance carriers do not pay for a Refraction. Refraction is the procedure which determines your best corrected visual acuity and will assist your physician in diagnosis of eye disease as well as to prescribe new glasses. Because it is difficult to reliably assess vision in children, a refraction is an integral part of the pediatric exam and is necessary to assess the health of the child's eye. In most incidences, this is a required portion of your eye exam, your Physician and or Technician will determine this. A fee of $25.00 is due at the time the service is rendered.

Other services or supplies my be considered non-covered by my health plan. I accept full responsibility for all items or services, which are determined by my health care plan not to be covered.

______________________________ Patient or Responsible Party Signature

______________________________ Date

MISSED APPOINTMENT POLICY

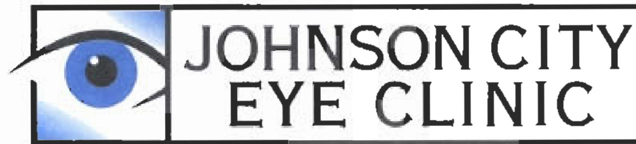
Although we will commit to work diligently to ensure the best for you and your eyes, it is important to recognize that, ultimately, the responsibility for your health care rests with you. If you miss an appointment within the time frame recommended by your doctor. We will make every reasonable effort to assist you in this regard; however repeatedly missed appointments are not compatible with quality health care. As such our policy for missed appointments is as follows:

1. For the first missed appointment, we will do our best to assist you with rescheduling.
2. For the second missed appointment within 1 year, it will be your responsibility to call our office to reschedule. If we do not hear from you, we will assume you have transferred your care to another doctor.
3. For the third missed appointment within 1 year's time, our office will not reschedule you for another appointment.

Please don't hesitate to ask if you have any questions.

_______________________________________ _______________
Patients Name Date

_______________________________________ _______________
Patient or legal Guardian Signature Date



Notice of Privacy Practices

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure or medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our policy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information abut your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purpose in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Fund Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the medical information of person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective

services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be a risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for the purpose other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complain form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.

JOHNSON CITY EYE CLINIC

NOTICE RECEIPT ACKNOWLEDGEMENT

Purpose: This form is used to confirm that an individual has received JOHNSON CITY EYE CLINIC'S Notice of Privacy Practices.

I, ____________________________, acknowledge that I have received Johnson City Eye Clinic's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature____ Date________________

RELEASE OF PROTECTED HEALTH INFORMATION

I, give permission for Johnson City Eye Clinic to release limited PROTECTED HEALTH INFORMATION to the person (s) listed below. The designated person (s) have permission to obtain appointment information, reschedule appointments, obtain account balance information, pick up glasses or contacts, physician orders, prescriptions, or samples. Please list the person (s) you wish to designate on the lines provided below.

1.____________________________________ Relationship____________________

2.____________________________________ Relationship____________________

3.____________________________________ Relationship____________________

Signature____ Date________________