COOL SPRINGS EYECARE

DONELSON EYECARE

Welcome to Cool Springs EyeCare and Donelson EyeCare!

We are looking forward to seeing you and helping you with your eye health and vision. As a comprehensive primary care practice, we provide a full range of services from vision examination to contact lenses and glasses. However, we also provide LASIK and other refractive surgery consultations, evaluate and determine surgical care for patients with cataracts, and treat and manage glaucoma, infections and eye emergencies.

We provide a *Lifetime of Eye Care* services, starting with our Infant See® exams, for babies between birth and one year of age and continuing through "mature" eye care for those nearing 100 years old! In between, we care for the vision needs of all ages whether you need good school vision, contact lens care, sports vision performance enhancement, a first pair of bifocals (no-line of course!), or eye health management and prevention of disease.

Most importantly, we think you will feel the friendliness and service extras that we pride ourselves with at these practices. Our staff is expertly trained and continually learning new aspects of eye care to better help patients. Our doctors work as a team and often consult with each other in specialized cases.

We work exceedingly hard to be accessible for appointments. No one likes to wait so we try to minimize both your wait for an appointment and the time spent waiting during your visit. Yet, you should never feel rushed in our office. Our goal is to see you this time and for years to come. This leads to a *Lifetime of Eye Care* provided for and with you.

We hope this packet of forms is convenient and helps save you time during your appointment. If there is anything else we can do for you before, during, or after your visit, do not hesitate to contact us. We look forward to seeing you soon . . . and for a long time into the future!

Drs. Jeff and Susan Kegarise, Owners
and the Doctors and Staff at Cool Springs EyeCare and Donelson EyeCare

COOL SPRINGS EYECARE

DONELSON EYECARE

PATIENT INFORMATION

Our priority is to keep your eyes healthy and functioning at their best now and in the future. Our decisions and recommendations will always be based on what we feel is the very best for you in terms of services, products, surgery or preventative care. Here are a few history questions that will help us give you the care you deserve.

Patient name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Emergency Contact Information:

Name: _____ Phone #: _____

Medical Professionals:

General Physician: _____ Phone #: _____

Specialist(s): _____ Phone #: _____

Last eye doctor: _____ Phone #: _____

Pharmacy: _____ Location: _____ Phone #: _____

Medical History:

Government Requirement

Height _____ Weight _____ Last known blood pressure reading _____/_____

Gender _____ Race _____ Preferred language: English/Spanish

Are you pregnant?	Yes	No
Tobacco use?	Yes	No
Alcohol use?	Yes	No
Drug or other allergies:	Yes	No

please list: _____

Please list any other medical conditions we should know about but not covered:

_____

_____

Medical Insurance:

Primary ID#: _____ Policy #: _____

Secondary ID#: _____ Policy #: _____

Responsible Party: (Circle one) Self Other Relationship & Name: _____

Vision Insurance: _____ ID#: _____

Updated 10/05/2021

COOL SPRINGS EYECARE

DONELSON EYECARE

Please circle "Yes" or "No" to indicate if you or a family member have or have had any of the following general medical or eye related conditions:

	PATIENT		FAMILY MEMBER(S)	
				Relation
AIDS/HIV	Yes	No	Yes	No _____
Arthritis	Yes	No	Yes	No _____
Asthma	Yes	No	Yes	No _____
Bleeding disorder (Hemophilia)	Yes	No	Yes	No _____
Blindness or Loss of Vision	Yes	No	Yes	No _____
Cancer	Yes	No	Yes	No _____
Cataracts	Yes	No	Yes	No _____
Chemical dependency	Yes	No	Yes	No _____
Diabetes	Yes	No	Yes	No _____
Drug Sensitivity	Yes	No	Yes	No _____
Emphysema	Yes	No	Yes	No _____
Eye surgery	Yes	No	Yes	No _____
type: _____				
Glaucoma	Yes	No	Yes	No _____
Heart condition	Yes	No	Yes	No _____
Hepatitis (type _____)	Yes	No	Yes	No _____
High blood pressure	Yes	No	Yes	No _____
Kidney disease	Yes	No	Yes	No _____
Lazy eye	Yes	No	Yes	No _____
Lupus	Yes	No	Yes	No _____
Migraine headaches	Yes	No	Yes	No _____
Pacemaker	Yes	No	Yes	No _____
Poor color vision	Yes	No	Yes	No _____
Retinal disease	Yes	No	Yes	No _____
Rheumatic Fever	Yes	No	Yes	No _____
Shingles	Yes	No	Yes	No _____
Skin conditions	Yes	No	Yes	No _____
Stroke	Yes	No	Yes	No _____
Thyroid conditions	Yes	No	Yes	No _____
Tuberculosis	Yes	No	Yes	No _____
Turned eye	Yes	No	Yes	No _____

Current Medications: (continued from front)

MEDICATION:	TAKEN FOR:

Updated 10/05/2021

COOL SPRINGS EYECARE

DONELSON EYECARE

THE FORM YOU ALWAYS HAVE TO SIGN

Of course there are forms to sign. Aren't there in every doctor's office? It's all here in black and white. We're obligated to present it to you, and you're obligated to give us your autograph on it. We don't want to bog you down in it because, really, what's the fun in this? You're here for great eye care, and we're here to give it to you. We promise it's all here, and if you have any questions feel free to ask our staff. Yes, the type is small. We're not trying to test your eyes already, just save a tree or two.

Payment: Payment is due at the time of service. This includes co-pays, deductibles, co-pay percentages and anything not covered by insurance. We accept checks, cash, Visa, MasterCard, AmEx and Discover. We also can help you set up payment plans with Care Credit for LASIK surgery. ***Initial:*** _____

Insurance: Your bill is your responsibility. We will do our best to help you understand your coverage, and we will file insurance as a courtesy to you whenever possible. Any existing balances after your claim is filed are due immediately. We will call you or send a statement to explain any of the charges, payments and amounts owed. ***Initial:*** _____

Contact lenses: Contact lens wear requires additional testing, evaluation and follow-up to ensure proper eye health and performance. There are additional fees associated with a contact lens evaluation beyond a normal eye exam. ***These fees are annual and are determined by the complexity of the case and time required.*** ***Initial:*** _____

Medical insurance vs. Vision insurance: Medical insurance can be filed for some diagnoses, such as conjunctivitis (pink eye), foreign bodies in the eye, glaucoma or suspicion of glaucoma, diabetes in the eye, cataracts, floaters, etc. Vision insurance, if you have separate coverage, usually pays toward an annual routine eye exam and contributes toward glasses, contact lenses and sometimes LASIK surgery. We will obtain insurance information on your vision and medical coverage, including copies of your cards. ***Initial:*** _____

Coordinated care: Our doctors treat an array of eye problems and diseases. Should the need arise for a surgical or other consultant on your case, your signature at the conclusion of these forms is your authorization for our doctors to discuss, share and transfer any and all clinical information and data pursuant to your care. ***Initial:*** _____

Appointment times: Appointments can be made online or by phone. Please let us know as soon as possible if you cannot make a scheduled appointment so we might use that time for other patients. You understand that we may remind you of appointments by e-mail, text or phone. ***Initial:*** _____

Unpaid balances, collections and insufficient funds: We will notify you by mail, e-mail or phone regarding any unpaid balance. We will make every effort to notify you in advance of charges incurred through the testing your doctor recommends. You have the right to ask at the time of service, prior to the test being performed, if any additional charges will be incurred. If you fail to do so you waive the right and will adhere to the customary billing and collection policies. Collection agencies are used only when necessary. ***Initial:*** _____

Refunds: Any refunds on your account will be processed as promptly as possible. They will be provided after all insurance on the account has been paid. Refund checks are processed monthly by the practice auditor and chief financial officer. ***Initial:*** _____

COOL SPRINGS EYECARE

DONELSON EYECARE

Dilation: Our office offers Optomap® retinal imaging for the convenience of patients who wish to avoid the side effects of dilation. Side effects can include light sensitivity, difficulty focusing, glare disability, problems reading or with near tasks, and driving difficulties. We understand that most patients will choose Optomap®. If you choose to be dilated you assume the risk of the possible side effects and will not hold liable Cool Springs EyeCare PLLC, Donelson EyeCare PLLC, its doctors, associates or businesses. You can request post-dilation sunglasses. ***Initial:*** _____

Refraction: We determine the prescription required for your eyeglasses or contact lenses. For patients with ***medical*** and eye health diagnoses, this is often a necessary special test. Insurance companies require us to bill this separately. The charge is $80. However, if you pay today there is a $30 time of service discount. Your cost today is $50. ***Initial:*** _____

HIPAA Privacy Practices: You understand that under the "Health Insurance Portability & Accountability Act of 1996" you have certain rights to privacy regarding your protected health information. You acknowledge that you have been informed and had access to Notice of Privacy Practices containing a more complete description of the uses and disclosures of your health information. You understand that Cool Springs EyeCare PLLC and Donelson EyeCare PLLC have the right to change their Notices of Privacy Practices from time to time and that you may contact these organizations at any time to obtain a current copy of the Notice of Privacy Practices. ***Initial:*** _____

Authorization, assignment and release: Your signature below authorizes Cool Springs EyeCare PLLC, Donelson EyeCare PLLC and their agents to release any and all information related to you or your dependent's care for the purpose of obtaining insurance compensation, pre-certification or medical records. By signing, you also acknowledge that you understand that Medicare or your insurance carrier may not cover all services. You will be fully responsible for any and all charges not covered by your insurance. Furthermore, you request that all payments on your behalf be paid directly to Cool Springs EyeCare PLLC or Donelson EyeCare PLLC. You also authorize that any holder of medical information about you release your secondary (or Medi-Gap) insurance carrier any information needed to determine these benefits or the benefits payable for related services. These assignments will remain in effect until revoked by you in writing.

I agree to allow Cool Springs EyeCare or Donelson EyeCare to leave detailed messages/results on my voice mail. I understand that it is my responsibility to inform Cool Springs EyeCare or Donelson EyeCare if there are any changes to the above information. **Initial:**_____

Marketing release: I give permission to Cool Springs EyeCare or Donelson EyeCare to release photos and videos of myself for communications on social media, email, marketing and other media outlets.
Initial:_____

Authorization to release information: I give permission to allow the release/discussion of my medical information to _____, relationship to patient _____, should I not be available.

_____ _____
Patient Signature (or Responsible Party if patient is a minor) Date

_____

Please print name of patient

Updated 10/05/2021

COOL SPRINGS EYECARE

DONELSON EYECARE

REFUND, RETURN AND CANCELLATION POLICY

PRESCRIPTION EYEWEAR

Cannot be returned for a refund. Warranty and exchanges may apply. See below.

FRAMES

All frames are warranted against defects in workmanship for a period of one year from the date of purchase. Frames may be exchanged for full credit one time for patient satisfaction up to 30 days from date of purchase. Lens fees may apply. See an optician for details.

PRESCRIPTION LENSES

Lenses will be made and inspected to the specification of the prescription given and with the material and options you have selected. If the lens has a manufacturers defect we will replace them with the identical item in the original prescription at no charge to you within 30 days of purchase.

COATINGS

Anti-reflective coatings and scratch coatings are warranted at no cost to you for a period of one year from the date of purchase.

NON-ADAPT POLICY

Lenses: If you are not satisfied with the lens performance, the lenses may be exchanged for another lens type, up to the original value. Change must be made within 30 days of original order. **No refunds will be given.**

Progressive Lenses: If for any reason you are not able to adapt to using the progressive lenses we will replace them, within 30 days of receipt, with either a pair of single vision lenses for distance or near, or a lined bifocal. **No refunds will be given.**

CANCELLATION POLICY

Once the lab has started your order, you may be eligible for a 50% refund. See an Optician for details.

OUTSIDE DOCTOR'S CHANGES

One doctor's change will be honored for a period of 30 days from the date of dispense. Costs associated with changes other than prescription will be responsibility of the patient. Subsequent changes will be made at 50% of original cost unless otherwise noted on order.

**Scratches and fatigue from obvious abuse are not considered defects. Manufacturer guidelines will apply.

Updated 10/05/2021