JAMES C. LODEN MD, PC
dba LODEN VISION CENTERS AND
THE NASHVILLE TN
OPHTHALMOLOGY ASC, LLC

LODEN iVISION CENTERS

LODEN VISION CENTERS
of PARIS, LLC
and VAN DYCK ASC, LLC

Patient History Information

Fill in all the blanks. Date and Sign on the back.

Date completed: _____ Chart Number: _____

Patient Information

Name: _____
(Last) (First) (Middle)

Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

Sex: _____ Race: _____ Date of Birth: _____ Age: _____

Social Security#: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Home Phone: _____ Cell Phone: _____

Work: _____ Employer: _____

Email: _____

Spouse or Parent Name: _____

Social Security#: _____ Date of Birth: _____

Employer: _____ Phone: _____

Primary Insurance

Primary: _____ ID#: _____ Group#: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Secondary Insurance

Secondary: _____ ID#: _____ Group#: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security#: _____

Who is your attending optometrist or ophthalmologist? _____

Address: _____ Phone: _____

When was your last visit? _____

Who is your medical Doctor? _____

Phone: _____

Contact Information

Who to contact in case of emergency (not living with you)

Name: _____ Phone: _____

Responsible Party: _____

Do you have a living will? _____ May we have a copy? _____

How were you referred to our office? _____
(Doctor, Friend, Radio Ad, Telephone Book)

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Conditions Of Registration

RELEASE OF INFORMATION: I authorize James C. Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery or Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC, to disclose all or part of my medical records to any insurance carrier or person employed by such carrier for the purpose of collection insurance benefits so long as I am listed on this account as having coverage with such carrier. This authorization includes but is not limited to release of information to employers for group insurance coverage, workmen's compensation carriers, welfare agencies, and referring MDs/ODs, if applicable to my claim for treatment. I hereby indemnify and release James C. Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery or Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC, from any and all responsibility relative to the release of such information.

ASSIGNMENT OF BENEFITS: I authorize James C. Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery or Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC , of all medical benefits applicable to my treatment by James C. Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery or Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC. I am totally responsible for payment of all fees for services rendered, irrespective of insurance coverage or other responsible parties. (This assignment is for both your Medicare benefit and any secondary insurance benefits. We will bill your secondary insurance direct from the office.)

PRE-ADMISSION: My insurance carrier requires Pre-admission approval: Yes_____ No_____. I understand that if my carrier requires pre-admission and I fail to acquire that approval, I will be responsible for any adverse financial effects.

SECOND OPINIONS: My insurance carrier requires second opinions for surgical procedures: Yes _____ No _____. I understand that if I fail to acquire a second opinion, my insurance carrier will reduce its reimbursement, therefore increasing my financial responsibility for payment.

TERMS FOR REGISTRATION: I understand that upon registration that acceptable insurance is required. Total balance is due day of service with an allowance made for insurance coverage approved and verified prior to service. Any exception to the above must be made before or at the time of registration.

PATIENT'S CERTIFICATION, AUTHORIZATION: I certify that the information given by me in applying for payment under title XVLL or XIX of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf to James C Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery or Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

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of PARIS, LLC and
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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PROVIDED BY JAMES C. LODEN MD, PC/dba LODEN VISION CENTERS AND THE NASHVILLE TN OPHTHAMOLOGY ASC, LLC and LODEN VISION CENTERS OF PARIS, LLC AND VAN DYCK ASC, LLC

Hereafter referred to as "providers"

I consent to the use or disclosure of my protected health information by the providers for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, conducting the health care operations of the providers. I understand that diagnosis or treatment of me by the physicians of the providers conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The providers are not required to agree to the restrictions that I may request. However, if the providers agree to a restriction that I request, the restriction is binding on the providers and on my physician(s).

I have the right to revoke this consent, in writing at any time, except to the extent that the providers or its physicians have taken in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health-care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the providers Notice of Privacy Practices prior to signing this document. The providers Notice of Privacy Practices have been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the providers. The Notice of Privacy Practices for the providers is also provided in the providers clinic area. This Notice of Privacy Practices also describes my rights and the providers duties with respect to my protected health information.

The providers reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a reserved notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Date	Description of Personal Representative's Authority

JAMES C. LODEN MD, PC
dba LODEN VISION CENTERS AND THE
NASHVILLE TN OPHTHALMOLOGY,
ASC, LLC

LODEN VISION CENTERS
of PARIS, LLC
and VAN DYCK ASC, LLC

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DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

In keeping with the Health Insurance Portability and Accountability Act (HIPPA), I, _____ hereby authorize the following providers: _____ to disclose the following protected health information to James C. Loden, MD, Terrence Doherty, MD, Thomas Bailey, MD, dba Loden Vision Center and LVC Outpatient Surgery and Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC

This protected health information is being used by the Center for the purpose of preparation for an outpatient surgery at the James C. Loden, MD, PC/dba Loden Vision Center and LVC Outpatient Surgery and Loden Vision Centers of Paris, LLC and Van Dyck ASC, LLC.

This authorization shall be in force and effect until _____/_____/_____

I understand that, as set forth in the Center's Privacy Notice, I have the right to revoke this authorization (in writing) at any time by sending notification to:

James C. Loden MD, PC/dba Loden Vision Centers
and LVC Outpatient Surgery
Attn: Privacy Officer
907 Rivergate Parkway C2020
Goodlettsville, TN 37072

Loden Vision Centers of Paris, LLC
and Van Dyck ASC, LLC
Attn: Privacy Officer
1024 Kelley Drive
Paris, TN 38242

I understand that a revocation is not effective to the extent that the Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that the Center will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights.
- Refuse to sign this authorization.

_____

Patient or Personal Representative Signature — Date

_____

Print Name of Patient or Personal Representative — Date

If Personal Representative's Signature appears above, please describe relationship to the patient.

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Name: _____ Date: _____ Height: _____ Weight: _____

Welcome to Loden Vision Centers. Our goal is to safely care for our patients. In order for us to achieve this goal we need your assistance in answering the following questions. Thank you for your time.

What problem(s) are you having with your eyes? _____

When was your last exam? _____ Who is your eye doctor?_____

Are you **ALLERGIC** to any medication? ☐ No ☐ Yes (if yes, please list along with reaction):_____

_____

Are you **ALLERGIC** to betadine? ☐ No ☐ Yes

Are you **ALLERGIC** to latex? ☐ No ☐ Yes (if yes, please list reaction): _____

_____

Do you have any problems with the following: (check all that apply)

☐ Itching	☐ Floaters	☐ Redness
☐ Burning	☐ Tearing	☐ Flashes of light
☐ Lids Crusting	☐ Swelling of eyelids	
☐ Discharge from eyes	☐ Dry feeling/scratchy	
Blurred vision **distance** ☐ Right eye ☐ Left eye ☐ Both eyes ☐ With glasses ☐ Without glasses	Blurred vision **near** ☐ Right eye ☐ Left eye ☐ Both eyes ☐ With glasses ☐ Without glasses	How long have you had blurred vision? _____ _____

Do you use any eye drops? ☐ No ☐ Yes: Name: _____

Do you wear contact lenses? ☐ No ☐ Yes: Type: _____

Do you now have or ever had any problems with the following:

Cataracts: ☐ No ☐ Yes
Glaucoma: ☐ No ☐ Yes
Crossed Eyes: ☐ No ☐ Yes
Retina Disease: ☐ No ☐ Yes
Cornea Disease: ☐ No ☐ Yes
Injury to Eye: ☐ No ☐ Yes
Other: _____

If you have been diagnosed with cataracts, how is your vision affection your daily living activities?

_____

	YES	NO		YES	NO
Difficulty driving at night			Difficulty seeing signs		
Judging distances			Difficulty taking medications		
Bothered by glare			Difficulty reading, sewing, cooking		
Blurred/Foggy vision			Difficulty walking		
Difficulty watching TV			Other		

Do you live alone? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes
Do you use street drugs? ☐ No ☐ Yes
Do you drive? ☐ No ☐ Yes
Do you use tobacco products? ☐ No ☐ Yes
Do you require walking assistance? ☐ No ☐ Yes
Do you use a walker, cane or wheelchair? (Circle one or more)

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SEE OTHER SIDE FOR ADDITIONAL QUESTIONS

Name: _____

Do you have or did you ever have any problems with the following:

	YES	NO		YES	NO
HEART			KIDNEYS		
CHEST PAIN If YES, date of last episode: _____ Cardiologist name: _____ Phone: _____			DIABETES – if YES, ☐ Insulin dependent ☐ Oral medication ☐ Diet controlled		
HIGH BLOOD PRESSURE			LIVER		
STROKE			SEIZURES		
ASTHMA			HEADACHES		
EMPHYSEMA			NERVOUS CONDITION		
SHORT OF BREATH			STOMACH PROBLEMS		
BRONCHITIS			THYROID		
TUBERCULOSIS			ARTHRITIS		
CANCER If YES, kind: _____ Date: _____			HEPATITIS Type: _____		
DO YOU HAVE A PACEMAKER?			DO YOU HAVE A DEFIBRILLATOR?		
ATRIAL FIBRILLATION			CONGESTIVE HEART FAILURE (CHF)		
CPAP			ACID REFLUX		
USE OXYGEN AT HOME?			AIDS		
SLEEP APNEA			HIV POSITIVE		

Do you have any other health problem(s) not listed above? ☐ No ☐ Yes; if yes, please list:

_____

Previous Surgery

EYES: ☐ No ☐ Yes; IF Yes ☐ RIGHT EYE ☐ LEFT EYE ☐ BOTH

Heart:	☐ No ☐ Yes	Hip/knee replacement:	☐ No ☐ Yes
Cancer:	☐ No ☐ Yes	Kidney stones:	☐ No ☐ Yes
Appendectomy:	☐ No ☐ Yes	Tonsillectomy:	☐ No ☐ Yes
Hysterectomy:	☐ No ☐ Yes	Gall Bladder:	☐ No ☐ Yes

Other: _____

MEDICAL DOCTOR: _____ **PHONE:** _____

Do any of your family members have?

Cataracts:	☐ No ☐ Yes	Retina Problems:	☐ No ☐ Yes
Glaucoma:	☐ No ☐ Yes	Diabetes:	☐ No ☐ Yes
Stroke:	☐ No ☐ Yes	Heart problems:	☐ No ☐ Yes
Cancer:	☐ No ☐ Yes	Other: _____	

Patient/Patient Representative's Signature: _____

Thank you for your time

_____ _____ _____
Technician's Signature Doctor's Signature Date

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Date: _____

Patient Name: _____ Chart No: _____

Pharmacy Name: _____ Phone: _____

Do you currently take aspirin, blood thinners or other anti-inflammatory medication? □ No □ Yes

Are you **ALLERGIC** to any medications? (if yes, please list along with reaction) _____

_____

Are you **ALLERGIC** to betadine? □No □Yes

Are you **ALLERGIC** to Latex? □No □Yes

Last Taken	Medication Name	Dosage	Medication Routine & Frequency	Reason for Medication

□ Drop schedule to be given at post-operative appointment

□ Start post-operative drops day of surgery

□ Resume all home medications

□ Dropless

Nurse's Signature: _____ Date: _____

Doctor's Signature: _____