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

LODEN VISION CENTERS

LODEN VISION CENTERS
Of PARIS, LLC
AND VAN DYCK ASC, LLC

Patient History Information

Fill in all blanks, sign, and date

Date completed: _____

Patient Information

Name: _____
(LAST) (FIRST) (MIDDLE)

Address: _____City: _____State: _____County: _____Zip Code: _____

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

Home Phone: _____ Cell Phone: _____Work Phone: _____ Email: _____

Preferred Contact: ❑ Text ❑ Email ❑ Phone Call Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Language Spoken: _____

How were you referred to our office? _____

(Doctor, Friend/Family, Web/Radio, Drive-by)

Emergency Contact Information

Emergency Contact Name: ___ _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Cell/Other Phone: _____

Responsible Party Name (required if patient is a minor): _____ Relationship to Patient: _____

Insurance Policy Holder Information

Insurance Subscriber Name: _____ Subscriber Relationship to Patient: _____

Subscriber Social Security: _____ Subscriber Date of Birth: _____ Subscriber Phone: _____

Eye and Medical Care Provider Information

Current Optometrist or Ophthalmologist: _____ Date of Last Visit: _____

Optometrist/Ophthalmologist Address: _____Phone: _____

Primary Care Physician/Medical Doctor: _____ Phone: _____

Conditions of Registration

I authorize James C. Loden, MD, PC/dba Loden Vision Centers, The Nashville TN Ophthalmology ASC, LLC, Loden Vision Centers of Paris, LLC, and/or Van Dyck ASC, LLC, assignment of all medical benefits applicable to my treatment by James C. Loden, MD, PC/dba Loden Vision Centers, The Nashville TN Ophthalmology ASC, LLC, Loden Vision Centers of Paris, LLC, and/or Van Dyck ASC, LLC. I understand that I am responsible for any unpaid charges due to failure to provide correct insurance information as well as for any balance due because of Co-Pay, Deductible, Referral/Authorization not obtained prior to visit or doctor not on insurance plan.

Patient/Responsible Party Signature: _____ Date: _____

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) How medical information about you may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read and the foregoing, received a copy of the Notice of Privacy Practices if requested, and is the patient, or the patient's personal representative.

Patient Name (print):_____DOB:_____

Patient Signature: _____ Date: _____

Patient Representative (print): _____Relationship to Patient: _____

Patient Representative Signature: _____Date: _____

FOR INTERNAL USE ONLY

Employee Name (print):_____

Employee Signature: _____ Date: _____

If applicable, reason patient's written acknowledgment could not be obtained

☐ Patient was unable to sign
☐ Patient refused to sign
☐ Other _____

PRIVACY NOTATION / CONSENT OF DISCLOSURE

By signing this authorization, I authorize Loden Vision Centers to share the selected information with the following individuals (such as spouse, parent, son/daughter, etc.):

- ❑ Appointment Details
- ❑ Medication Information
- ❑ Medical/Surgical Information
- ❑ Billing/Financial Information
- ❑ Any/All Information
- ❑ Decline

Individuals authorized to receive selected information and relationship:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

By signing this form, I am giving my permission to this facility to contact me for appointments, services or education that may be of interest to me. I recognize that I may sign at the time of my appointment.

Patient Name (print):_____DOB:_____
Patient Signature: _____ Date: _____
Patient Representative / Signature: _____Relationship to Patient: _____

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CONTACT LENS EXAM AGREEMENT

Patient Name _____ **Date** _____

The process of acquiring and obtaining a contact lens prescription involves the evaluation and management of a properly fitted lens. In addition to the comprehensive eye exam, the fitting process includes:

1) Measuring the curvature and size of the cornea to determine proper fit of the contact lens.
2) Determining the parameters, lens type and prescription for you.
3) If needed, insertion of a diagnostic lens to evaluate fit, coverage and movement.
4) Follow-up care and changes are included for **90 days** from the initial exam date, not to exceed 3 follow-up visits without additional costs. Follow-up visits beyond this time are subject to a fee.

As with any medical device, there are some potential risks involved. The risks are sight-threatening complications for patients who choose extended wear lenses, those who do not replace their lenses according to the replacement schedule given, and those who do not use proper disinfecting solution and contact lens care.

Always remove your lenses immediately if you experience any of the following, unexplained conditions: eye pain or redness, any unusual discomfort, watering or discharge from the eye, decreased vision or sensitivity to light. If the problems do not resolve right away, make an appointment to be seen at our clinic or another specialist as soon as possible.

CONTACT LENS REMINDERS

DO	DON'T
• Wash your hands before inserting/removing your lenses • Clean and disinfect lenses as directed • Replace lenses as prescribed, and replace lens case every 3 months • Call our office if you experience any unusual symptoms or problems	• Do not wear your lenses longer than prescribed • Do not wear your lenses if you have red eye or loss of vision • Do not reuse disinfecting solution • Do not use tap water for cleaning • Do not wear lenses if you notice a chip or tear in them

FITTING FEE POLICY

New Patient: $60 (Spheres – Excluding Monovision), $70-$120 (Toric – astigmatism, Monovision, Toric, Bifocal, Rigid Spheres)
Established Patient: $50 (Spheres – Excluding Monovision), $70-$120 (Toric – astigmatism, Monovision, Toric, Bifocal, Rigid Spheres)

Contact lens prescription will not be released until the Fitting Fee is paid in full and contact lens prescription is finalized.
If for any reason the patient wishes to discontinue wearing contact lenses during the initial period after dispensing of the lenses, the FITTING FEE IS NON-REFUNDABLE.

Contact lens fitting services are typically considered *cosmetic*, and charges cannot be submitted through MEDICAL insurances. It is the patient's responsibility to provide any VISION INSURANCE information prior to the evaluation and/or contact lens order.
Contact lens order must be paid in full before the order will be placed.

Contact lens purchases can be returned for a refund within 30 days of purchase. Only **unopened** boxes are eligible for return.

By signing below, you acknowledge that you have read and understand the risks, benefits and policy.

_____ _____
Patient Signature Date

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REFRACTION POLICY

ACKNOWLEDGEMENT
I hereby acknowledge and understand that during the course of my treatment certain procedures may need to be performed that **most insurance companies, including Medicare, do not cover**. I also understand that ***Vision Plans*** are insurance benefits that do cover refractions. Generally, a vision plan will pay for refraction annually. This is often a part of their benefit for routine eye examinations only.

Why is it necessary?
Refraction is sometimes necessary depending on the patient's diagnosis and/or visual complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction is necessary to see if this is due to a need for corrective lenses or due to a medical problem.

Our office policy is to charge **$45.00** for this procedure in addition to the office visit. This is due at the time services are rendered, unless covered by your vision insurance.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. Co-pays and deductibles are separate from, and not included in, the refraction fee.

_____ _____
Print Name: DOB:

_____ _____
Patient Signature Date

Note: Refractions are listed under exclusions, with Medicare benefit policy 100.02, Section 90:

"Routine physical checkups: eye glasses, contact lenses and eye examinations for the purpose of prescribing, fitting or changing eye glasses, eye refractions by whatever practitioner and for whatever purpose performed."

You may find additional information online at cms.hhs.gove/manuals