JAMES C. LODEN, MD, PC
LODEN VISION CENTERS AND
MUSIC CITY SURGERY
CENTER

LODEN VISION CENTERS

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

Patient History Information

Fill in all blanks, sign, and date

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:____ Language Spoken: ____________________________

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

Pharmacy: ____

Pharmacy Name Address City Phone Number

Were you referred to us by a doctor? If so, who: ____

If not referred to us by a doctor, how did you hear about us: ______________________________

(Friend/Family, Facebook, Instagram, Web/Radio, Drive-by)

Eye and Medical Care Provider Information

Current Optometrist or Ophthalmologist:______________________________Date of Last Visit: ______________

Optometrist/Ophthalmologist Address:____Phone:________________

Primary Care Physician/Medical Doctor:____________________________________Phone: ________________

Emergency Contact Information

Emergency Contact Name:______________________________________Relationship to Patient: ______________

Emergency Contact Cell Phone: ______________________________Other Phone:___________________________

Responsible Party Name *(required if patient is a minor)*:__________________________Relationship to Patient:______________

Insurance Policy Holder Information

Subscriber Name: ____________________________________Subscriber Relationship to Patient: ____________________

Subscriber: Social Security:____________________Date of Birth:______________Subscriber Phone: ____________________

Conditions of Registration

I authorize James C. Loden, MD, PC/dba Loden Vision Centers, Music City Surgery Center, 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: ________________

If you are <u>not</u> the patient:

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 ____________________________________

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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 the selected information and relationship:

Name: ______________________________ Relationship to Patient: ______________________

Name: ______________________________ Relationship to Patient: ______________________

Name: ______________________________ Relationship to Patient: ______________________

Name: ______________________________ Relationship to Patient: ______________________

On occasion, Loden Vision Centers may send out information regarding an upcoming promotion or sale. Please select if you agree to receive promotional materials via email.

Your personal information will be used for Loden Vision purposes only and is **never sold to third parties**.

- ❑ Agree to receive promotional materials via email
- ❑ Decline

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: ____________

If you are not the patient:

Patient Representative (print): ______________________ Relationship to Patient: ______________

Patient Representative 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. Meaning, a Refraction must be done to determine an accurate prescription for glasses.

Our office policy is to charge **$65.00** for this procedure in addition to the office visit unless the Refraction is covered by your insurance. This amount is due at the time services are rendered.

Follow-up care and changes are included for **90 days** from the initial exam date, not to exceed 2 follow-up visits without additional costs. Follow-up visits beyond this time are subject to a fee.

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

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

Financial Policy

No Show/Late Cancellation/Late Arrival

Loden Vision Centers is committed to providing all patients with exceptional care. In our efforts to honor that commitment, we do not over book our appointment schedules so that we may dedicate the proper attention to each of our patients. Because we are a specialty clinic, we have many patients waiting to schedule appointments. When a no-show or late cancellation/reschedule occurs, another patient loses an opportunity to receive care. This policy provides a guideline to improve appointment access, minimize wait times and maximize the time our physicians spend with patients.

Definition of No-Show

A scheduled appointment for which a patient did not arrive and there was no indication from the patient or legal guardian that they would not be arriving for the appointment at least two business days prior to the appointment time.

No-Show Policy

Patients or their legal guardians are expected to keep their scheduled appointments. If they wish to cancel or reschedule their appointments, they should contact us no later than two business days prior to their scheduled appointment time. Cancellations/reschedules not made inside of the two business days window will be considered a no-show. If a two business days' notice is not received, a $ 50 fee will be charged to your account. This fee is not covered by insurance and is therefore the sole responsibility of the patient.

Late Cancellation/Reschedule Policy

We understand that there are times when you must cancel/reschedule an appointment due to emergencies or obligations for work or family. However, when you call with less than two business days' notice to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is cancelled or rescheduled with less than two business days' notice, you will be charged a $50 fee.** This fee is not covered by insurance and is therefore the sole responsibility of the patient.

Late Arrival Policy

Patients arriving more than 15 minutes late for a scheduled exam or non-urgent office visit may be required to reschedule their appointment and could be subjected to a late cancellation/reschedule fee of $50. This fee is not covered by insurance and is therefore the sole responsibility of the patient.

Patients arriving more than 15 minutes late for an urgent work-in appointment will be seen as soon as the schedule allows.

Print Name: ______________________ DOB: ______________________

Signature: ______________________ Date: ______________________