

McCabe Vision Center
New Patient Packet

Patient Name: _____
(Last) (First) (M.I.) (Nick Name)

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____

Employer: _____ Work Phone: (____)____-____

Date of Birth: ____/____/____ (Age:____) Sex: Male Female

Social Security Number: ____-____-____

Marital Status: Married Single Widow Spouse's Name: _____

Spouse's S.S.N.: ____-____-____ Spouse's Date of Birth: ____/____/____

Email Address: _____

Emergency Contact: _____ Best Phone Number: (____)____-____

Emergency Contact: _____ Best Phone Number: (____)____-____

Family Physician: _____ Phone Number: (____)____-____

Referring Physician: _____ Phone Number: (____)____-____

If a physician did not refer you, who may we thank for referring you? _____

If a Minor or Workman's Comp. Claim

Guarantor Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone Number: (____)____-____ Evening Phone Number: (____)____-____

Driver's License Number: _____ SSI# _____ Expiration Date : ____/____/____

Insurance Information

Primary Insurance: _____ ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ____/____/____

Secondary Insurance: _____ ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ____/____/____

McCABE VISION CENTER

MEDICAL HISTORY

Patient Name: _____

Check all that apply to you: NONE APPLY

Anemia
Arthritis
Asthma
Breathing Problems
Bronchitis
Emphysema
Hay Fever
Allergies
Headaches / Migraines
Tremors, Parkinson's
Convulsions, Epilepsy
High Blood Pressure
Duration: _____

Acid Reflux
Heart Attack
Chest Pain, Angina
Other Heart Problems
Swelling Ankles
Kidney Problems
Thyroid Disorders
Hepatitis, Liver Disease
Cancer
Stroke
Diabetes Mellitus
Duration: _____
Insulin or Pills
High Cholesterol

Ulcers
Cataracts
Glaucoma
Retinal Tear
Amblyopia
Crossed Eyes
Color Blindness
Retinal Degeneration
Pregnancy/Nursing
HIV/AIDS
Other _____

Medication Allergies: _____

Do you have, or do you see the following? NONE APPLY

Burning
Redness
Dryness
Spots
Sensitivity to Light

Night Blindness / Glare
Flashes of Light
Headaches
Floaters
Sudden Loss of Vision

Nausea
Pain
Tearing
Itching
Fainting and/or Dizziness

Gritty Sensation
Double Vision
Blurred Vision

Please list all surgeries and dates:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

What is your current occupation? _____

Do you work at a computer? _____ How many hours? _____

Do you work outside? _____ How many hours per day? _____

Are your eyes at risk of injury? _____ Explain: _____

What are your hobbies? _____

How many hours do you spend on your hobbies each day? _____ Each week? _____

McCabe Vision Center
122 Heritage Park Drive, Ste 100
Murfreesboro, TN 37129
Phone: 615-904-9024
Fax: 615-904-0337

MEDICAL RECORDS RELEASE FORM

Section A: (Will Be Completed by Front Office Staff)

I hereby authorize the disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal Privacy Regulations.

Patient Name: _____ Date of Birth ____/____/____

Physicians Providing Information:

Physician Receiving Information:

McCabe Vision Center
122 Heritage Park Drive
Murfreesboro, TN 37129

Information Requested: Previous Records

Section B: (Must Be Completed By Patient)

I give McCabe Vision Center permission to request my records from the physicians listed above.

Signature of patient or patient's representative

Date

Printed Name of patient's representative: _____

Relationship to patient: _____

I do not give McCabe Vision Center permission to request my records from any previous physicians.

Signature of patient or patient's representative

Date

Printed Name of patient's representative: _____

Relationship to patient: _____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The Practice has a Notice of Privacy Policy and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Patient or Representative

Printed Name-Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____

In front of _____

Printed name-Practice representative

McCabe Vision Center

Professional ethics require your signature and permission before we can release any information

Concerning your health records to anyone, including Family.**

Is there anyone in your family that **we may release information** to concerning your health records?

If so, please list their names below: NONE

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I give permission for McCabe Vision Center to release any information concerning my health records to the above mentioned family members

Your Signature

Date

McCabe Vision Center Financial Policy

Here at McCabe Vision Center, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

Payment for Service is Due at the Time Services are Rendered - We accept cash, personal checks, and all major credit cards.

Commercial Insurance – **Co-payments must be paid at time of service.** Because we are under contract with your insurance company, we will file your insurance, provided the information is current and given to our office in a timely manner.

HMO Insurance – It is **your responsibility to obtain a referral from your PCP prior to your appointment.** If a referral is not obtained, the appointment will be rescheduled.

Worker's Compensation – It is **your responsibility to call your employer to get the visit authorized.** We will file your company's insurance. In the event you fail to report your injury to your employer, or the condition is determined not the result of a Worker's Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

Self Pay Patients – **You are responsible for all charges incurred at the time of service.** However, if payment is made at the time services are rendered, we will discount 20% off of the total amount.

Children of Divorced Parents – **Payment is due at the time of service,** no matter who is responsible by order of the divorce decree.

Financial Agreement – We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. To enable our office to file your insurance, you must provide accurate information at *each* visit.
- **Not all services are a covered benefit in all contracts.** Some insurance companies arbitrarily select certain services that they will not cover (i.e., refractions, astigmatism revisions, certain injections into the eye, Lasik surgery and evaluations, etc.).
- Due to timely filing limits for insurance companies, you have 30 days from the date services are rendered to provide our office with updated insurance information. If the correct information is not received within 30 days, you will be responsible for the charges.

All Charges are Your Responsibility From the Date Services are Rendered. On any account balance after 120 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account. If it becomes necessary to collect any sum due through a collection agency, then the patient agrees to pay all reasonable costs of collection.

- *I authorize McCabe Vision Center to release to all of my Insurance companies any information necessary including, but not limited to the diagnosis and records of any treatment and examination or surgery rendered to me.*
- *I authorize the use of this form in all my insurance admissions, and I permit a copy of this authorization to be as valid as the original. In the event that this account becomes delinquent I agree to pay all costs of collections, which may include a collection fee of 33.3% to be added to my balance, and any applicable court costs.*
- *I understand that all charges are my responsibility from the date that services are rendered.*
- *I also understand that not all services are covered by my insurance company (i.e. **REFRACTIONS, ASTIGMATISM REVISIONS, CERTAIN INJECTIONS INTO THE EYE, LASIK SURGERY AND EVALUATIONS, ETC.**).*
- *I understand that it is my responsibility to obtain a referral from my PCP prior to my appointment if one is needed.*
- *If I am a self pay patient, I understand that I am responsible for all charges incurred at the time of service, and that if payment is made at the time services are rendered 20% will be discounted off of the total price.*

The refraction is a procedure that Dr. McCabe and Dr. Simon must do so that you can obtain your prescription and so they can check the overall health of your eyes. Unfortunately, most insurance companies do not cover this procedure. Since it is necessary to a thorough eye exam, we will be charging \$35.00 for the refraction on the date of service. If it is not paid, filed with insurance, and not covered, the patient will be billed for the full price, which is \$45.00.

THERE WILL BE A \$25.00 CHARGE FOR ANY MISSED APPOINTMENT.
THERE IS A \$25.00 CHARGE FOR ANY MEDICAL RECORDS THAT WE RELEASE TO YOU.

We must emphasize that as your eye care provider, our relationship and concern is with you and your sight, not the insurance company.

I have read and understand the above Financial Policy and been offered a copy of the Notice of Privacy (HIPPA) pamphlet.

Signature: _____ Date: ____/____/____