



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 are in need of 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



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: \_\_\_\_\_
Email: \_\_\_\_\_ Employer: \_\_\_\_\_
Employment Status: \_\_\_\_\_ Occupation: \_\_\_\_\_
Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Professionals:

General Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
Specialist(s): \_\_\_\_\_ Phone: \_\_\_\_\_
Last eye doctor: \_\_\_\_\_ Phone: \_\_\_\_\_
Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical History:

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.

Table with 5 columns: Condition, YOURSELF (Yes/No), FAMILY MEMBER(S) (Yes/No). Rows include AIDS/HIV, Arthritis, Asthma, Bleeding disorder, Blindness or Loss of Vision, Cancer, Cataracts, Chemical dependency, Diabetes, Drug Sensitivity, Emphysema.



Eye surgery type: _____	Yes	No	Yes	No
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

**YOURSELF**

**FAMILY MEMBER(S)**

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

**Government Requirement:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Last known blood pressure reading \_\_\_\_/\_\_\_\_  
 Gender \_\_\_\_\_ Race \_\_\_\_\_ Preferred Language: English/Spanish

Are you pregnant? Yes No  
 Tobacco or 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 above:

\_\_\_\_\_

**Current Medications:**

**MEDICATION:**

**TAKEN FOR:**




## 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.

**Individual Photos:** We're doing something new and adding an individual photo to your patient record. This assists our doctors and staff in providing continuity of care whether you receive care here or through e-mail or on the phone. We'll now have a face to go with your name. **Initial:** \_\_\_\_\_

**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 and Discover. We also can help you set up payment plans 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 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:** \_\_\_\_\_



**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 "Heath 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:** \_\_\_\_\_

**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:** \_\_\_\_\_

**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.

**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.

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:** \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (or Responsible Party if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of patient