Welcome to Our Office!

Our mission is to provide the most personalized and comprehensive care and the highest quality of products with an unprecedented focus on state-of-the-art technology and customer service. Dr. Stamper and the staff of Visionary Eyecare Center are committed to providing a truly exceptional experience for each and every patient.

Last Name: ________________ First Name: ________________ M.I. ______

Preferred Name: ____________ Street Address: ________________________

City: ______________ State: ______ Zip Code: ________ SSN: ______________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

DOB: ____/____/______ ☐ Male ☐ Female Race: ____________ ☐ Single ☐ Married

Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Military ☐ Retired ☐ Not Employed

Employer/Occupation: ____

Please tell us how you heard about us: ____________________________________

May we thank them for referring you to us? ☐ Yes ☐ No *(We will not disclose your personal information.)*

May we occasionally share with you any special announcements or promotions about our office via Email? ☐ Yes ☐ No

(We will not share your contact information.) Email: ____________________________

Is your insurance under your: ☐ Spouse ☐ Parent ☐ Guardian ☐ Self

Responsible Party's Name: ______________________________ DOB: ____/____/______

Responsible Party's Address: ____

City: ______________ State: ______ Zip Code: ________ SSN: ______________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Patient Responsibility and Assignment

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit, and I am responsible for payment to **Visionary Eyecare Center, PLLC** due at the time of service for all deductibles, co-pays, co-insurances, and services not covered by my insurance plan. I certify that the information contained herein is complete and correct. I hereby authorize photocopies of this form to be valid as the original.

______________________________________ ______________

Signature of Patient or Responsible Party **Date Signed**

Medical History Questionnaire

Patient's Name: ______________________________ DOB: ______________

Primary Care Physician: ______________________ Location: ______________

Specialist Physician: ________________________ Specialty: ______________

DO YOU… *(check box if "Yes")*

- ☐ wear contact lenses? Brand: ______________ ☐ Soft ☐ Toric ☐ Gas Perm ☐ Bifocal
- ☐ work at a computer?
- ☐ have more than one pair of prescription glasses? ☐ Distance ☐ Reading ☐ Computer ☐ Sunglasses ☐ Sports
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ spend time outdoors? How many hours per week? ________ ☐ Boating/Fishing ☐ Hunting ☐ Sports ☐ Other
- ☐ have times you'd rather not wear glasses?
- ☐ want information on Laser Vision Correction?

Do you have any allergies to medications? ☐ No ☐ Yes: ______________________

Please list below all medications you take regularly: (Rx, OTC, vitamins, birth control, recreational drugs, steroids, etc)

☐ None ____

____

PERSONAL Health History

Please check any of the following **conditions you currently have or have had** in the past:

☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Bone	☐ Retinal Tear/Detach
☐ Diabetes	☐ Seizures	☐ Genitourinary	☐ Macular Degeneration
☐ Stroke	☐ Cancer (*type:* ________)	☐ STDs	☐ Lazy Eye
☐ Heart Disease/Attack	☐ Respiratory	☐ HIV	☐ Eye Surgery
☐ Cholesterol	☐ Sinus/Allergy	☐ Lupus	☐ Eye Injury
☐ Thyroid	☐ Blood/Lymph	☐ Flashes of Light	☐ Sandy/Gritty Eyes
☐ Arthritis	☐ Kidney	☐ Glaucoma	☐ Itchy Eyes

☐ Other: ____

Are you pregnant? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes: ________ packs per day

FAMILY Health History

Please check any of the following conditions your **immediate family currently has or has had** in the past (parents, grandparents, siblings, and children).

☐ Blindness	☐ Retinal Tear/Detachment	☐ High Blood Pressure
☐ Glaucoma	☐ Stroke	☐ Diabetes
☐ Lazy Eye	☐ Cancer (*type:* ______________)	☐ Heart Disease/Attack
☐ Macular Degeneration		

____ ______________

Signature of Patient or Responsible Party **Date Signed**

100 Country Club Drive, Suite 106 • Hendersonville, Tennessee 37075 • Phone: 615-824-4246 • Fax: 800-216-3102
Visit our website at **www.visionary-eye.com**

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

- *Treatment:* We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
- *Payment:* We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
- *Health Care Operations:* We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health Oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and Administrative Proceedings:* We may disclose information in response to an appropriate subpoena or court order.
- *Law Enforcement Purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious Threat to Health or Safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- *Research:* We may use or disclose information for approved medical research.
- *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for workrelated injuries or illness.

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Notice of Privacy Practices (cont)

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and each examination room. You can also request a copy of our notice at any time. For more information, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Visionary Eyecare Center, PLLC
Eric Stamper, Optometrist and Owner
100 Country Club Drive, Suite 106
Phone: 615-824-4246

Effective Date

The effective date of this notice is 5/1/08.

Acknowledgement of Receipt

I hereby acknowledge receipt of the Notice of Privacy Practices given to me by Visionary Eyecare Center, PLLC.

____

Printed Name of Patient

____

Signature of Patient/Responsible Party

____

Date Signed