CENTER FOR SIGHT, P.C.
EYE DISEASE AND SURGERY

Stephen R. Franklin, MD
Katherine H. Laney, OD

Name: _____Date of Birth: _____/_____/_____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Sex: (Circle One) M F Marital Status: (Circle One) Single Married Divorced Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Primary Care Provider_____

Please check your preferred contact method below.

_____Automated Phone Call (Circle: Home Cell Work) _____Email _____Text Message

Employer: _____Occupation:_____

Employer Address: _____ Preferred Language: _____

Race: _____ Ethnicity: (Circle One) *Hispanic/Latino* *Not Hispanic/Latino*

We are required by law to request Race/Ethnicity information from you. If you prefer not to complete the Race/Ethnicity portion of the form, please write refused in the space above.

Parent or Guardian Information: (If the patient is under 18)

Name: _____ Date of Birth: _____/_____/_____

SSN: _____ Employer: _____

Daytime Phone: _____ Evening Phone: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Insurance Information:

Policy Holder's Name: _____ D.O.B.:_____/_____/_____

Relationship to Patient: _____ SSN: _____

- I authorize Center for Sight to enroll me in the Patient Portal website so I can view my medical records and communicate with the office staff online._____ (Initial)
- I authorize the release of any medical information necessary to process my claims. I also request payment of benefits to the provider on all claims that he may accept assignment on. I understand that I am responsible for all non-covered services and any balance that may not be covered by insurance._____ (Initial)
- I authorize the release of any information in my chart to any medical practitioner, insurance company, doctor, hospital, pharmacy, optical dispensary, or any other medical institution to which I may be referred to assist with my care. _____(Initial)
- I acknowledge the Notice of Privacy Practices is kept on file in the practice and is available for my review and can be explained to me if I have any questions._____ (Initial)
- I understand that an annual refraction fee of $55.00 will not be covered by most medical insurance policies and that I am responsible for payment of this fee plus my co-pay (if applicable) at the time of service. A refraction is a vision test that is a necessary part of a complete eye exam. _____ (Initial)

Signature: _____ Date: _____

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Consent to Contact:

I, _____ authorize Center for Sight, PC to contact me with automated voice calls via any telephone number provided for any reason related but not limited to my care, appointments, collections, and/or billing.

Signature: _____ Date: _____

HIPAA Authorization:

I authorize Center for Sight to leave messages with medical information on voicemail / answering machine at (please check all that apply):

Cell Phone_____ Home Phone_____ Work Phone_____

The following individual(s) are authorized to receive information pertaining to any medical history and treatment that I have received:

Name_____Relationship_____

Name_____Relationship_____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at 7800 Conner Rd. Powell, TN 37849. My revocation will be effective once received by Center for Sight.
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPPA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. I may receive a copy of this form and Center for Sight's privacy policy upon request.

Printed Name: _____

Signature: _____ Date: _____

Notice of Possible Non-Covered Services:

I _____understand that my insurance will be filed as a courtesy and that I am responsible for any charges or non-covered services not paid by my insurance company (even when due to incorrect information given by me or failure to supply the correct information within 24 hours of the date of service unless special arrangements have been made). I agree to pay any unpaid amount on my account no more than 90 days after the date of service. I understand that a finance charge of 2% per month of the unpaid balance may be added monthly. Should collections become necessary, the responsible party agrees to pay an additional 40% for collection agency fees, plus all legal fees of collection, including attorney fees, court costs, and filing fees.

Signature: _____ Date: _____ Date of Birth: _____

If patient is unable to sign, underage, or has a legal representative, please fill out additional information below.

Authorized Representative Name: _____

Relationship to Patient: _____

Signature of Authorized Representative: _____ Date: _____

Center for Sight, PC Return Policy:

Your purchases from Center for Sight, particularly in the case of optical goods, are custom ordered and cannot be resold, therefore, purchases of this kind are non-refundable and non-returnable. Optical orders cannot be altered or canceled after they had been submitted. We submit orders at time of initial payment. We will, however, work with you to ensure order accuracy and satisfaction with all optical orders. Other items sold such as cords, OTC readers, etc., that are NOT custom products, can be returned in unused and clean condition within 14 calendar days. Items such as contact lenses can be returned only if the boxes are unopened. Eye vitamins cannot be returned for any reason to Center for Sight.

Signature in receipt of return policy (Patient or Authorized Representative): _____

Printed name (Patient or Authorized Representative): _____Date: _____

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Optos Retinal Image/Screening

Center for Sight, PC is pleased to offer ultra-wide digital retinal images and screening as part of your comprehensive eye exam today. This image will give you and the doctor a more detailed view of the interior of your eye without using dilation. This will also allow us to keep a permanent record of images to compare for changes that may occur over time.

Many eye diseases can develop without significant symptoms. The benefit of using retinal imaging enhances our ability to detect early signs of disease that may appear on your retina. The image is not painful and takes just a few seconds to perform. We are required to report a dilated eye exam for certain diagnoses. For this reason, your doctor may dilate your eyes as well as perform the Optos retinal imaging.

Some medical insurance plans may not cover the cost of the retinal image/screening unless there is a problem with the health of your eyes. Vision insurances **DO NOT** cover this service.

The retinal image/screening is offered to you for $40.00, which will be collected at the time of service.

Please initial beside your choice.

_____ I have read and understand the above, and agree to the Optomap retinal image/screening and the $40.00 fee.

_____ I have read and understand the above, and decline the Optomap retinal image/screening.

_____ I have read and understand the above, and decline the Optomap retinal image /screening until further discussion with my doctor.

Patient Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If patient is under the age of 18, signature of authorized representative, parent or legal guardian required)