PATIENT REGISTRATION FORM

KELLY VISION CENTER
(615) 868-2877

PATIENT INFORMATION					
Patient's Name (first, middle, last):		☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.			
Email Address:	Social Security Number:	Birth date: / /	Age:	Sex: ☐ M ☐ F	
Street Address:	Home Phone: ( )	Cell Phone: ( )			
City:	State:	Zip code:			
Occupation:	☐ Full-Time ☐ Part-Time	Employer:			
[For Students] School:		Grade:			
Preferred Language:	Ethnicity:	Referred by:			
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Spouse Name:	Spouse Cell Phone: ( )			
PRIMARY CARE PHYSICIAN (PCP)					
Name:	Address:	Phone: ( )			
IN CASE OF EMERGENCY					
Emergency Contact:	Relationship:	Phone: ( )			
INSURANCE INFORMATION					
Name of PRIMARY Insurance & ID#:	Name of SECONDARY Insurance & ID#:				
*If you are not the insurance policy holder, please list the policy holder information below					
Insurance Policy Holder Name (first, middle, last):	Relationship to Insured:	Birth date: / /	Age:	Sex: ☐ M ☐ F	
Street Address:	Social Security Number:	Cell Phone: ( )			
City:	State:	Zip code:			
PHARMACY					
Name:	Street Address, City, State, Zip Code:				

1. I give permission for Dr. Kelly to discuss my visit with my guardian or spouse or other (listed below).

   Other (name): _______________________________________ Phone: (____)_____________

   Patient or Guardian Signature:_______________________________________ **Date:** ___________________

2. I give permission for Dr. Kelly to release records to my doctor(s) upon their request.

   Patient or Guardian Signature:_______________________________________ **Date:** ___________________

3. I request that payment of authorized insurance benefits or any other third-party payer be made to me or on my behalf to Dr. Marie C. Kelly and/or its independent contractor for any services furnished by the provider. I authorize any holder of medical information about me to release to the agents or any third-party payers any information needed to determine these benefits or the benefits payable for related services.

   Patient or Guardian Signature:_______________________________________ **Date:** ___________________

MEDICAL HISTORY QUESTIONNAIRE

KELLY VISION CENTER
(615) 868-2877

Patient's Name (first, last):		Birth date: / /	Today's date: / /
Last Eye Doctor (name):	Last Eye Exam (date): / /	Current Weight (lb):	Current Height: _____ ft ______ in

What is your eye problem/complaint today? *Please describe this problem as best as you can*

____

Medications: *List all medications that you currently take (including Over-The-Counter, Vitamins, Supplements, Oral Contraceptives, etc.). Do not worry about filling out this section if you already have a medication list that we can copy. Thank you.*

____

____

____

Any eyedrops or eye medications? ____

Are you allergic to any medications? *If so, please list*: _____________________________________

____

Do you want contact lenses or glasses Rx at today's appointment?

☐ Contact Lenses Rx only ☐ Glasses Rx only ☐ BOTH ☐ Neither ☐ I don't know

PERSONAL SOCIAL HISTORY		
Do you wear glasses?	☐ Yes ☐ No	If Yes, how many pairs?:
Do you wear contact lenses?	☐ Yes ☐ No	If Yes, what brand/type?:
Do you drive?	☐ Yes ☐ No	
Are you nursing or pregnant?	☐ Yes ☐ No	
Do you use tobacco products? *(dip, e-cigs, cigarettes)*	☐ Yes ☐ No	If Yes, do you use every day?: ☐ Yes ☐ No If No, have you used in the past?: ☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No	If Yes, what type?:
Do you drink alcohol?	☐ Yes ☐ No	If Yes, how often?:
Have you ever had a blood transfusion?	☐ Yes ☐ No	
Have you ever had an STD?	☐ Yes ☐ No	
Birth order: ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ >Fifth ☐ Only child ☐ Identical Twin ☐ Fraternal Twin		
How often are you on a computer/TV/Phone a day? ☐ 1-2 Hrs. ☐ 2-4 Hrs. ☐ 4-6 Hrs. ☐ 6-8 Hrs. ☐ >8 Hrs.		

FAMILY OCULAR/MEDICAL HISTORY *Checkmark and fill in all that apply*	**Yes**	**No**	**Relationship to you** *(Brother, Sister, Mother, Father, Grandmother, Grandfather, etc.).* List all that apply.
Blindness			
Glaucoma			
Cataracts			
Retinal disease			
Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
High Blood Pressure / Hypertension			
Other Disease(s) / Prematurity			

PATIENT MEDICAL HISTORY

Check mark for past or present

ALLERGIES (seasonal allergies, food, etc.) ☐ Yes, explain: ____

CARDIOVASCULAR	☐ Stroke	☐ Heart Attack	☐ High Cholesterol	☐ High Blood Pressure	
Explain:					
CONSTITUTIONAL	☐ Anemia	☐ Fever	☐ Weight Changes	☐ Dizziness	☐ Sleep Problems
Explain:					
ENDOCRINE	☐ Diabetes	☐ Gout	☐ Thyroid Disease	☐ Pituitary Complication(s)	
Explain:					
If Diabetic:	☐ Insulin	☐ Non-Insulin	☐ Last blood sugar level: _____	Date taken: ____ /____ /______	
GASTROINTESTINAL	☐ Diarrhea	☐ Pancreatitis	☐ Hepatitis		
Explain:					
GENITOURINARY	☐ Genital Complication(s)	☐ Kidney Complication(s)	☐ Bladder Complication(s)		
Explain:					
EAR, NOSE, THROAT	☐ Dryness	☐ Hearing Loss	☐ Dental Complication(s)	☐ Sinus Complication(s)	
Explain:					
HEMATOLOGIC/LYMPHATIC	☐ Sickle Cell Anemia	☐ Blood Disorder	☐ Breast Cancer		
Explain:					
IMMUNOLOGIC	☐ Herpes	☐ HIV	☐ Lyme	☐ Sarcoidosis	☐ Tuberculosis
	☐ Covid-19	☐ Cancer (Type:_________ Location:______________)			
Explain:					
INTEGUMENTARY	☐ Lupus	☐ Skin Disease/Disorder			
Explain:					
MUSCULOSKELETAL	☐ Arthritis	☐ Joint/Muscle Pain			
Explain:					
NEUROLOGICAL	☐ Seizures	☐ Dyslexia	☐ Parkinson's	☐ Headaches/Migraines	☐ Multiple Sclerosis
Explain:					

PATIENT OCULAR HISTORY

Check mark for past or present. Provide details in the following blanks (date, which eye, ***surgeries****, or other procedures).*

☐ Blindness or Loss of Vision: ____

☐ Glaucoma: ____

☐ Cataracts: ____

☐ Retinal Disease: ____

☐ Macular Degeneration: ____

☐ Eye Injury: ____

☐ Eye Infection: ____

☐ Strabismus (Eye Turn In/Out): ____

☐ Amblyopia (Lazy Eye): ____

☐ Dry Eye: ____

☐ Other Ocular Disease(s): ____

List any other surgeries that you have had:

____

____

____

____

____

SIGNATURE: ____________________________

Date: _____ /______ /_______

**By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor to examine, diagnose, and initiate treatment as deemed appropriate.*

HIPAA COMPLIANCE PATIENT CONSENT FORM

KELLY VISION CENTER
(615) 868-2877

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the family members allowed below:

____

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ______________________________________ Date: ____________________

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

KELLY VISION CENTER
(615) 868-2877

Providing the best possible eye care involves a mutual understanding between patient and provider. Please review the following policies, checkmark in the space provided, and let us know if we can answer any questions.

**Initial in the spaces provided*

_____ I authorize Dr. Marie C. Kelly to release information regarding my care to my insurance company in order to expedite claims or transfer records, should such events be required.

_____ I understand that Dr. Marie C. Kelly participates with vision plans (ex. VSP, EyeMed, & etc.) for routine wellness exams, as well as medical insurances for eye health issues. The appropriate plan will be billed for any given service. Unfortunately, Dr. Marie C. Kelly is unable to participate with every HMO. I understand that if Dr. Kelly does not participate with my plan, I am free to pay out of pocket at the time of service and seek any out-of-network reimbursement directly from my insurer. This office will assist in this effort where possible.

_____ While Dr. Marie C. Kelly makes every effort to verify my insurance coverage and benefits before services are provided, I understand that such information is NOT an official or legally-binding decision of my out-of-pocket expenses. Verification of coverage is done as a courtesy only and is not a guarantee of insurance coverage. Ultimately, my final costs are dependent on the final decision of my insurance carrier. I understand any copay estimate given to me prior to my examination may turn out to be different from the final decision of my insurance carrier. I agree that I am fully responsible to Dr. Kelly for payment of all charges, including any amount in excess of previous copay estimates.

_____ I understand that if my insurance company fails to pay its anticipated balance in full, it is my responsibility to pay the doctor's bill. I will pay collection fees, attorney's fees, court cost, etc. for the purpose of collection on delinquent accounts.

_____ In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

_____ I give permission for Dr. Kelly to release records to my doctor(s) upon their request.

_____ I request that payment of authorized insurance benefits or any other third-party payer be made to me or on my behalf to Dr. Marie C. Kelly and/or its independent contractor for any services furnished by the provider. I authorize any holder of medical information about me to release to the agents or any third-party payers any information needed to determine these benefits or the benefits payable for related services.

_____ (Account Balances) Kelly Vision Center will require that patients with self pay balances do pay their account balances to $0 prior to receiving further services by our practice. Patients who have questions about their bill(s) or would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ I understand there is a 30% restocking fee for all returned materials. There are no refunds after 30 days.

_____ I understand that I must pay 50% of the total payment before my glasses can be ordered. I also understand that my glasses must be completely paid for before I can pick them up.

_____ I understand there is a $45 fee for all returned checks.

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: _______________________________________ Date: ____________________

CANCELLATION/ NO SHOW POLICY

KELLY
VISION
CENTER
(615) 868-2877

Thank you for trusting your vision care to Kelly Vision Center. When you schedule an appointment with Kelly Vision Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below.

- Effective January 1, 2021, any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 48 hours' notice** will be considered a No Show and charged a **$25 fee.**
- Any established patient who fails to show or cancel/reschedule an appointment with no 48 hours' notice a **second time** will be charged a **$50 fee**.
- If a **third,** No Show or cancellation/reschedule with no 48-hour notice should occur the patient may be dismissed from Kelly Vision Center.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Kelly Vision Center during regular business hours Monday through Thursday 8AM-5PM.

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____________________________________ Date: ___________________

SCAN / DILATION CONSENT FORM

KELLY VISION CENTER
(615) 868-2877

3D OCT Maestro Retinal Scanner

- ✓ Provides a digital image of the retina surface for early detection of eye disease
- ✓ Is fast, easy, and has no side-effects
- ✓ May replace the need for dilation
- ✓ Becomes a permanent part of your medical file for future comparisons

Your doctor strongly believes that the 3D OCT Maestro scanner is an essential part of your comprehensive eye exam and recommends it for all patients once per year. In addition to detecting eye conditions, such as macular degeneration and glaucoma, the retinal scanner can also detect other health issues, such as diabetes, heart disease, and some cancers. For patients with vision insurance, **the fee for the *3D OCT Maestro scanner* is *$39.00,*** in addition to your vision exam copay fee.

Dilation of the Pupil

- ✓ Is a common diagnostic procedure used to better examine the interior of the eye
- ✓ Requires eye drop administration
- ✓ Requires roughly half an hour to take full effect
- ✓ Temporary side effects include light sensitivity and blurred vision, especially at near distances
- ✓ No additional fee

It takes 4-6 hours for your vision to return to normal. During this time, you must exercise caution when walking down steps, driving a vehicle, operating dangerous machinery, or performing other tasks that may present a risk of injury. If you have any special transportation needs, please let us know so that they can be arranged prior to dilation.

NOTE

Dilation and/or an OCT scan is highly recommended by our doctors at Kelly Vision Center to check the health of the eye. A retinal OCT scanner will give us a more detailed image of the retina than dilation; however, when checking for cataracts, dilation is necessary to check the full view of the eye's lenses.

Please check mark all that apply:

☐ I consent to having a 3D OCT Scan of my eye for $39*.

☐ I consent to having my eyes dilated today (at no additional fee) if the doctor believes it is necessary, and I understand the side effects of dilation explained above.

☐ I prefer to have neither dilation nor an 3D OCT Scan. *In refusing these services, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to a lack of information which may have been provided from a retina scan and/or dilation.

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: _______________________________________ Date: ____________________

*This applies to patients with vision insurance or paying out of pocket. Patients who choose to use medical insurance will be responsible for covering up to the full cost of the scan depending on their deductible.