SHOFNER vision center

Midtown Medical Plaza
2004 Hayes St., Suite 335
Nashville, TN 37203

R. Stewart Shofner, MD

p: 615.340.4733
f: 615.340.4734
info@shofnervisioncenter.com

Patient Registration

Today's Date: _____

Name: (First, MI, Last) _____

Date of Birth: _____ Age: _____ Gender: M☐ F☐ Marital Status: S☐ M☐ D☐ W☐

Address: _____ City: _____

State: _____ ZIP: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Preferred Daytime Contact: H☐ W☐ C☐ Email ☐ Social Security Number: _____-_____-_____

Driver's License State: _____ Driver's License Number: _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____

State: _____ ZIP: _____ Occupation: _____

School Name (If full-time student over 18): _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relation: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Who can we thank for referring you? _____

How did you hear about us? (Please check all that apply) ☐Google ☐Radio- Channel: _____

☐Facebook ☐Twitter ☐Yelp ☐Bing/Yahoo ☐www.shofnervisioncenter.com

☐ Other: _____

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Patient Registration, continued

Guarantor of Account, if different than Patient: _____

Address: _____ City: _____

State: _____ ZIP: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Date of Birth: _____ Social Security Number: _____-_____-_____

I certify that, to the best of my knowledge, the above information is correct and true. I do understand, however, that I am ultimately responsible for treatment. I understand that I will be billed for any remaining balance after insurance has paid (if billed), and that it is my responsibility to pay this remainder. I further understand that if any insurance denies the claim, I will be billed for the entire balance.

_____ _____
Signature of Patient or Guarantor Date

I authorize the release of any medical information for the HIPAA approved reasons of TPO- Treatment, Payment, and Health Care Operations. I further authorize release of payment (assign benefits) from my insurance directly to R. Stewart Shofner MD, PC (dba Shofner Vision Center). In the event that I receive a payment from my insurance company in error, I understand that I will be billed by Shofner Vision Center to obtain this payment for services that were rendered to me.

_____ _____
Signature of Patient or Guarantor Date

I authorize Shofner Vision Center to notify me via land line or cell phone call, text, or email for the following:

☐ Yes ☐ No Appointment reminder, by personal or recorded message, by email, or by text.

☐ Yes ☐ No To obtain insurance information, or obtain payment via any office, collection agency, or other contact by automated dialer, recorded message, by direct call, by email, or by text.

☐ Yes ☐ No A message to call the office in regards to surgery or other clinical information.

_____ _____
Patient Name Patient's Date of Birth

_____ _____
Signature of Patient or Guarantor Date

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Notice of Privacy Practice (HIPAA) Acknowledgement Form

I acknowledge that I have received a copy, or have been provided the opportunity to read the Notice of Privacy Practice (HIPAA) for the following entities: R. Stewart Shofner MD, dba Shofner Vision Center.

_____ _____
Patient Name Patient's Date of Birth

_____ _____
Signature of Patient or Guarantor Date

I authorize ONLY the following individuals to receive information about my health status, which may include protected health information via phone, email, fax, or any other method of communication:

_____ _____
Print Name of Authorized Individual Relationship to Patient, Date of Birth

_____ _____
Print Name of Authorized Individual Relationship to Patient, Date of Birth

_____ _____
Print Name of Authorized Individual Relationship to Patient, Date of Birth

I understand that Shofner Vision Center will only release my protected health information to the individuals listed above. All other requests for protected health information must be made in accordance to Shofner Vision Center's office HIPAA policy and procedure manual.

_____ _____
Patient Name Patient's Date of Birth

_____ _____
Signature of Patient or Guarantor Date

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Financial Policy

The goal of Shofner Vision Center is to provide you with the best care possible. Although the costs of medical care continue to rise, we will do all we can to provide affordable care, and work with you financially. Below, you will read a summary of our financial policies. Please review these carefully, initial each item, and sign and date the form.

_____I understand that payment is expected at the time service is rendered, unless other arrangements have previously been made. This includes applicable coinsurance and copayments for participating insurance companies.

_____I understand that cash, personal checks (in-state only), VISA, and MasterCard are accepted for payment. I also understand that HSA and FSA cards are accepted, provided that they have a VISA or MasterCard logo. I understand there may be a $15.00 charge for returned checks.

_____I understand that in-house financing is not available, but I may be offered a chance to finance my care with an application through Care Credit or other financing options.

_____I understand that I am responsible to cancel an appointment 24 hours prior to the appointment date/time. I understand that if I miss any appointment, other than Post-Op care, I may be charged $25.00.

_____I understand that I may be charged $25.00 for each instance of Disability/FMLA paperwork preparation.

_____I understand that Shofner Vision Center will file my healthcare claims to my insurance on my behalf as a courtesy. I understand that I am responsible for my deductible, copay, and coinsurance. I also understand that if the insurance denies the claim, I may be responsible to contact the insurance company, or to pay the claim in full. I may again, be offered a chance to finance my care with an application through Care Credit.

_____I understand that if I have a credit on my account of less than $20.00, this amount will be retained on the account to be credited toward future balances, unless a written request for the refund is received. Amounts greater than $20.00 will be automatically reviewed and refunded to the patient/guarantor.

_____I understand that if I am enrolled in a managed care plan (HMO), a referral, or authorization may be required before seeing a Physician at Shofner Vision Center. I understand that this is ultimately my responsibility, and I may be asked to obtain this before treatment. I further understand that I may be responsible for payment if the referral or authorization is not obtained.

I have read and understood the Shofner Vision Center's financial policy. I agree to assign insurance benefits to R Stewart Shofner MD, PC (dba Shofner Vision Center). I also agree that if it becomes necessary to forward my account to a collection agency for any remaining balance due, I will be responsible for any fee charged by the collection agency for the cost of the collections.

_____ _____

Signature of Patient or Guarantor Date

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Medication and Allergy Record

Today's Date: _____

Patient Name: _____ Date of Birth: _____

☐ I have no known drug allergies.
☐ I have no known environmental allergies.
☐ I have no known substance allergies.

☐ I have drug allergies.
☐ I have environmental allergies.
☐ I am allergic to latex.
☐ I am allergic to adhesive tape.
☐ I am allergic to Betadine.
☐ I am allergic to Steroids.
☐ I am allergic to Fluorescein.

Allergy Table

Allergy- Drug or Environmental	Reaction
Example Allergy- latex gloves…	*Severe rashes, itching, and burning…*

Medication Table

Please include all prescription and over-the-counter medications such as aspirin, contraceptives, and others.

Medication Name	Dose	Frequency	Comments
Example Med-Valium…	*20 milligrams…*	*Once a day-before bed…*	*For anxiety…*

******IF ADDITIONAL LINES ARE NEEDED, PLEASE WRITE MEDICATION ON THE BACK OF THIS SHEET.******

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Personal Medical and Ocular History, page 1

Why are you here today? (Please check all that apply) ☐Routine Eyecare ☐Contact Lenses ☐I think I have an infection or injury ☐Post-Op Follow-Up ☐I think I have a Cataract ☐LASIK/PRK Consultation ☐ BOTOX ☐ Other: _____

Do you smoke? ☐ Yes ☐ No ☐ Frequency: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Frequency: _____

Do you take recreational drugs? ☐ Yes ☐ No ☐ Type and Frequency: _____

Do you drive? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No ☐ Frequency: _____

How old is your prescription?_____

What type of contact lenses do you wear? ☐ Soft Daily Wear ☐ Soft Extended Wear ☐ Toric ☐ Gas Permeable

What brand of contact lenses do you wear? _____

Do you wear glasses? ☐ Yes ☐ No ☐ Frequency: _____

How old is your prescription?_____

Do you/Have you use(d) prescription eye drops? ☐ Yes ☐ No ☐ Brand: _____

Are you pregnant, or planning to become pregnant? ☐ Yes ☐ No

Have you been pregnant in the last 12 months? ☐ Yes ☐ No

Are you breast-feeding? ☐ Yes ☐ No

Are you currently, or do you plan to become a member of the United States Armed Forces? ☐ Yes ☐ No

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Personal Medical and Ocular History, page 2

Do you currently have problems in any of the following areas?
(Please check all that apply and provide information in the comments section)

Ocular Concern	Yes	No	Comments
Blurred Vision			
Burning Sensation			
Crossed Eyes/Lazy Eye			
Difficulty Driving			
Distorted Vision (halos)			
Double Vision			
Drooping Eyelid			
Dryness			
Excessive Watering			
Eye Pain/Soreness			
Fluctuating Vision			
Foreign Body Sensation			
Glare/Light Sensitivity			
Herpes of the Eye			
History of “Pink Eye”			
Infection			
Injury/Scar			
Itching			
Keratoconus			
Loss of Center Vision			
Loss of Side Vision			
Mucous Discharge			
Night Vision Problems			
Recurrent Corneal Erosion			
Scratchy Feeling			
Tired Eyes			

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Family Medical and Ocular History

Have you, or a family member been diagnosed with any of the following? (Please check all that apply and provide information in the comments section)

Medical Concern	Me	Family Member	Comments
Arthritis			
Asthma			
Cancer			
Cataracts			
Diabetes			
Dialysis			
Glaucoma			
Heart Disease			
Hepatitis			
High Blood Pressure			
HIV/AIDS			
Implanted Heart Device			
Kidney Disease			
Macular Degeneration			
Migraines			
MRSA			
Retinal Detachment			
Sickle Cell Anemia			
Stroke			
Thyroid Disease			
Tuberculosis			