Medical Notes	***STAFF USE ONLY***
OP=	
PVS=	
OSS=	
TS=	

Administrative Notes ***STAFF USE ONLY***

Amount	Method	Staff	OD/OS	Date

NAME (First, MI, Last):_____ Date of Birth:_____ Age:_____

Male / Female: _____ Social Security #:_____ Marital Status:_____

Address, City, State & Zip: _____

Primary Phone #: _____ Secondary Phone #:_____

Email address:_____

Employer: _____ Occupation:_____

Emergency Contact Name:_____ Relationship:_____ Phone #:_____

Pharmacy Name:_____ Phone #:_____ Fax #:_____

INSURANCE INFORMATION

PRIMARY Insurance Company:_____

Subscriber ID#:_____ Group #:_____ Insurance Phone #:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber information (if different than patient): Date of Birth:_____ Social Security #:_____

SECONDARY Insurance Company:_____

Subscriber ID#:_____ Group #:_____ Insurance Phone #:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber information (if different than patient): Date of Birth:_____ Social Security #:_____

PHYSICIAN INFORMATION

Eye Doctor:_____ Phone #: _____

Address, City, State & Zip:_____

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

Address, City, State & Zip:_____

Did your doctor refer you? (**circle**) **Yes** **No** If yes, which doctor?_____

WHAT BROUGHT YOU TO WANG VISION 3D LASIK & CATARACT CENTER?

Circle all that apply: **Internet search** **Seminar** **Our website** **Social media** **Radio Ad** **Print Ad**
Wang Vision patient **(Name):**_____ Other (fill in):_____

PLEASE READ AND SIGN THE NEXT PAGE (Payment Policy).

Wang Vision Institute
1801 West End Ave., Suite 1150
Nashville, TN 37203
615-321-8881 (phone)
615-321-8874 (fax)

Patient Financial Responsibility Agreement

I, _____, understand that I am responsible for, and agree to pay in full, all fees for services rendered to me by Wang Vision Institute which are not covered by my insurance carrier. I understand that insurance may not cover all of the fees associated with my treatment, possibly even those which my healthcare provider and I deem necessary for my optimal care. My insurance carrier may consider some or all of these services "Not Covered" or "Not Medically Necessary". Some of these services include, but are not limited to, the following:

- Refractive surgery evaluations for procedures including, but not limited to: LASIK, SMILE, PRK, Forever Young Lens Surgery, etc.
- Routine eye exams
- Second opinion evaluations after a previous refractive procedure, including but not limited to: RK, AK, LASIK, SMILE, PRK, Intraocular lens implants, Intacs, Crosslinking, etc.
- Refractions for glasses
- Cataract Surgery
- Multifocal implantable lenses
- Intacs and ring segments
- Phototherapeutic Keratectomy (PTK)

In the event my insurance carrier denies to cover services rendered to me by Wang Vision Institute, I acknowledge that I am financially responsible for payment in full of the fees associated with these services, and I agree to make such payments by the date on which they are due.

_____ _____
Patient Signature Date

_____
Printed Name

WANG VISION MEDICAL HISTORY FORM

Name: _____ Date: _____/_____/_____

DOB____/____/____ Last Medical Exam ____/____/____ Last Eye Exam____/____/____ Eye Dr_____

Name of Parent / Guardian (if Patient is a Minor):_____

PERSONAL MEDICAL HISTORY (Current or past):

CARIOVASCULAR	YES	NO
High blood pressure	☐	☐
Irregular heart beat	☐	☐
Congestive heart failure	☐	☐
High cholesterol	☐	☐
Heart attack	☐	☐
Bleeding problems	☐	☐
DVT or PE (blood clot)	☐	☐
Heart stents/surgery	☐	☐
Type & date:_____		
Other cardiovascular	☐	☐

RESPIRATORY	YES	NO
Asthma	☐	☐
COPD/Emphysema	☐	☐
Sleep apnea	☐	☐
Other respiratory	☐	☐

GASTROINTESTINAL	YES	NO
Acid reflux	☐	☐
Crohn's	☐	☐
Ulcerative colitis	☐	☐
Hepatitis	☐	☐
Cirrhosis of liver	☐	☐
Other gastrointestinal	☐	☐

GENITOURINARY	YES	NO
Kidney disease/failure	☐	☐
Kidney stones	☐	☐
Have you ever taken Flomax	☐	☐
Other genitourinary	☐	☐

OTHER	YES	NO
Cancer	☐	☐
Type & date:_____		
HIV	☐	☐
Shingles	☐	☐
Cold sores	☐	☐

SKELETOMUSCULAR	YES	NO
Arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Gout	☐	☐
Degenerative disk disease	☐	☐
Other skeletomuscular	☐	☐

NEUROLOGICAL	YES	NO
Migraines	☐	☐
Stroke	☐	☐
TIA (mini-stroke)	☐	☐
Seizures/epilepsy	☐	☐
Neuropathy	☐	☐
Fibromyalgia	☐	☐
Parkinson's disease	☐	☐
Multiple Sclerosis	☐	☐
Dementia	☐	☐
Other neurological	☐	☐

ENDOCRINE	YES	NO
Type 1 diabetes	☐	☐
Type 2 diabetes	☐	☐
Thyroid	☐	☐
Other endocrine	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Anxiety disorder	☐	☐
ADHD	☐	☐
PTSD	☐	☐
Bipolar	☐	☐
Other psychiatric	☐	☐

DRUG ALLERGIES (Include drug & reaction) NONE ☐

_____

_____

_____

MEDICATIONS (INCLUDE DOSE & FREQUENCY):

_____

_____

_____

_____

_____

_____

FAMILY HISTORY (Living or deceased)

DISEASE/CONDITION	YES	NO	UNSURE	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Corneal Disease (specify type)	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____

SOCIAL HISTORY

Do you drive? ☐ yes ☐ no

Are you pregnant or nursing? ☐ yes ☐ no

Tobacco use: ☐ current ☐ past ☐ never Type: _____ Amount/day: _____ year quit: _____

Alcohol: ☐ current ☐ past ☐ never Drinks/week: _____

Recreational drug use: ☐ current ☐ past ☐ never Type: _____ Frequency: _____

OCULAR HISTORY

Do you have dry eyes? ☐ yes ☐ no If yes, characterize your symptoms: ☐ mild ☐ moderate ☐ severe

Are you currently using any eye drops? ☐ yes ☐ no If yes, which ones _____

Have you ever used any eye drops? ☐ yes ☐ no If yes, which ones _____

Have you been told you have cataracts? ☐ yes ☐ no If yes, by whom & when? _____

Have you been diagnosed with any other eye conditions? ☐ yes ☐ no If yes, by whom & when?

_____

Do you wear contact lenses? ☐ yes ☐ no How many years? _____ Date you discontinued wear _____

Type of CL: ☐ Soft ☐ Soft Toric ☐ Rigid Gas Permeable (RGP)

LIST ANY EYE SURGERIES

Procedure:	Which eye:	Surgeon:	Date:

Notice of Privacy Practices for Protected Health Information

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**.**

Uses & Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your doctor or staff member may have to disclose your health information, including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your doctor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes, other administrative purposes and/or to efficiently and effectively run our practice.
4) Your doctor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine or voicemail.

You have the right to refuse to give us authorization to contact you to provide an appointment reminder, information about treatment alternatives or other health-related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health-related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we have described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses and Disclosures Without Your Consent Or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your Right To Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.164.508 (b)(5)(i).
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write to us at:

Wang Vision Institute 1801 West End Avenue, Suite 1150 Nashville, TN 37203

Your Right To Limit Uses Or Disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree with your restrictions. However, if we agree with your restrictions, they are binding on us. If we do not agree with your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right To Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health to you in person at the time you receive optometric services from us. We may also mail you information regarding your health or about the status of your account. If you would like to receive information about your health or the services that we provide at a place other than your home, or if you would like the information in a different form, we will do our best to accommodate any reasonable request. To help us respond to your needs, please make any request in writing.

Your Right To Inspect And Copy Your Health Information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your Right To Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests made during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right To Obtain A Paper Copy Of This Notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Wang Vision Institute 1801 West End Avenue, Suite 1150 Nashville, TN 37203

To Contact Us

If you would like further information about our privacy policies and practices, please contact: Wang Vision Institute
1801 West End Avenue, Suite 1150 Nashville, TN 37203 615-321-8881

This notice is effective as of_____. This notice will expire seven years after the date upon which the record was created.
By signing below, I acknowledge that I have received a copy of this notice.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

_____ _____

Authorized Provider Representative Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient _____

Wang Vision Institute
APPOINTMENT REMINDERS AND
HEALTH CARE INFORMATION AUTHORIZATION

Your doctor and members of the practice's staff may need to use your name, address, phone number and your clinical records to contact you regarding appointments, follow-up care, payment or other issues related to your care. If this contact is made by phone and you are not at home or at work, a message will be left on your answering machine or voicemail. By signing this form, you are giving us authorization to contact you when deemed necessary by our office.
I, _____, authorize Wang Vision staff to contact me regarding appointments as stated above.

_____ _____
Patient's Signature Date

Marketing Authorization

Any time the doctors or staff of Wang Vision contact you, for example to thank you for a referral or for attending a seminar, this is considered "marketing". Due to changes in privacy laws, we must have your authorization to send you such materials. From time to time, our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. The doctors and staff at Wang Vision Institute may need to use your health information, including your name, address, phone number and your clinical records for the purpose of marketing products and services to you.

I, _____, authorize the Wang Vision staff to contact me regarding products or services that I may have an interest in purchasing based on my health information, or to contact me regarding referrals.

_____ _____
Patient's Signature Date

Insurance Disclosure

We accept selected insurance plans for medically necessary office visits. However, payment for all services is expected the day of your visit wherever applicable. In cases of refractive surgery, your carrier is likely to determine that the procedure is "not medically necessary", and therefore, not covered. For patients coming for medical reasons who have coverage by insurance carriers other than those we accept, or for whom further testing is deemed necessary by the doctor, we are happy to assist you in submitting to your insurance carrier to request reimbursement. Should further tests be recommended, it is your decision whether to accept the recommendation and pay for these services that day, or seek further testing elsewhere. It is your responsibility to be informed and understand the benefits set forth by your insurance carrier regarding your medical benefits.

_____ _____
Patient's Signature Date

Research Disclosure

I authorize Wang Vision to publish any photographs, maps or pertinent information concerning any care as may be needed for professional medical journal, books or seminars in the interest of medical education, knowledge and research. I understand that I will not be mentioned by name, nor will I be identifiable from my photographs.

_____ _____
Patient's Signature Date

Directions to Wang Vision Institute

1801 West End Ave, Suite 1150, Nashville, TN 37203
(615) 321-8881 (O), (615) 321-8874(fax)
www.wangvisioninstitute.com

Wang Vision is located at the corner of 18th Ave South and West End Ave, on the 11th floor of the 1801 West End building (see photo below).

If you have difficulty finding our office, please call us at 615-321-8881, and we will be happy to guide you to our location.

For directions, please go to our website: www.wangvisioninstitute.com

1801 West End Ave. Building
view from West End

DETAILED DRIVING DIRECTIONS:

From Smyrna, Murfreesboro, Chattanooga, Antioch (and surrounding cities)
Take 1-24 West to 1-40 West. Take the 209-A exit (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page.***

From the Nashville Airport, Mt. Juliet, Lebanon, Cookville, Knoxville (and surrounding cities)
Take 1-40 West. Take the 209-A exit (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page.***

From Brentwood, Franklin, Huntsville, AL (and surrounding cities)
Take 1-65 North to 1-40 West. Take the 209-A exit (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page.***

From Belle Meade, Bellevue (and surrounding cities)
Take Harding Pike/West End Ave toward downtown. Go past Centennial Park and Vanderbilt University. Turn right onto 18th Ave South. ***See parking instructions on the other side of this page***.

From Dickson, Jackson, Memphis (and surrounding cities)
Take 1-40 East. Take the 209-B exit (Broadway/Demonbreun). Get into the far right lane. Turn right onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page***.

From Clarksville, Paducah, KY (and surrounding cities)
Take 1-24 East to 1-65 South to 1-40 East. Take the 209-B exit (Broadway/Demonbreun). Get into the far right lane. Turn right onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page***.

From Hendersonville, Madison, Gallatin, Louisville, KY (and surrounding cities)
Take 1-65 South to 1-40 East. Take the 209-B exit (Broadway/Demonbreun). Get into the far right lane. Turn right onto Broadway. At the Broadway/West End Ave split, stay to the right (West End). Turn left onto 18th Ave South. ***See parking instructions on the other side of this page***.

Parking and Building Entrance Instructions

Please be sure to park in the **1801 West End Ave** parking garage. **PLEASE DO NOT PARK** in any **reserved** parking spots, nor in any private parking spots outside the garage that belong to other businesses in the area! **BRING YOUR LICENSE PLATE NUMBER INTO OUR OFFICE SO WE MAY VALIDATE YOUR PARKING.**

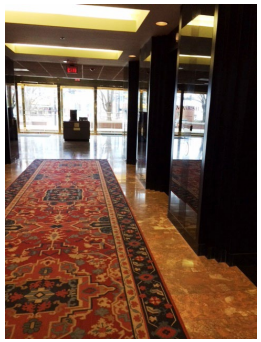
1) The entrance for the **1801 West End Ave** parking garage is on 18th Ave South, directly behind our building.

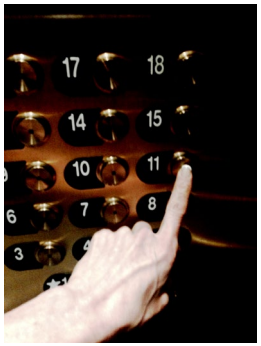
2) **After you park your car, write down or take a photo of your license plate and present it to us when you check in for your appointment so we can activate your validation.**

3) To enter the building from the garage, walk across the alleyway between the 2 structures (or use the walkway on the 2nd level of the garage).

4) Enter the building, after crossing the alleyway.

5) Enter an elevator, located to the right of the security desk, push floor 11.





6) The entrance to Wang Vision is on the 11th floor right as you exit the elevator. **Be sure to give your parking ticket to our staff to validate!**

7) **If you gave us your license plate number during your visit** to Wang Vision, your parking will have been automatically validated, so you may exit the garage at the same location you entered it.