COOL SPRINGS
Surgical Associates

Aaron Porter, MD • Daniel Weikert, MD • Nicholas Hackett, MD

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
Preferred Pharmacy: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
If Patient is a minor, Responsible Party: _____

INSURANCE INFORMATION

Primary Insurance: _____
Member ID #: _____ Group #: _____
Policy Holders Information (if different than above):
Name: _____ Date of Birth: _____
Social Security: _____ Sex: _____ Relation: _____
Secondary Insurance: (if applies): _____
Member ID #: _____ Group #: _____
Policy Holders Information (if different than above):
Name: _____ Date of Birth: _____
Social Security: _____ Sex: _____ Relation: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for any balance including deductible, coinsurance, copayment, and/or non-covered services. I also authorize **Cool Springs Surgical Associates** or my insurance company to release any information required to process claims.

Patient Signature: _____ Date: _____

If Patient is a minor, Parent/Guardian Signature: _____

HEALTH HISTORY

Name: _____ **DOB:** _____ **Acct #:** _____

Height: _____ **Weight:** _____

OCULAR HISTORY

Last Eye Exam ☐ Never ☐ Date: _____
Last Dilated Exam ☐ Never ☐ Date: _____

☐ Wears glasses ☐ NO ☐ YES
☐ Wears contact lenses ☐ NO ☐ YES ☐ Soft contacts ☐ Hard contacts

Contact lens solution: _____

Patient Conditions:

☐ None	☐ Cataract	☐ Corneal disorder
☐ Glaucoma	☐ Narrow angles	☐ Macular degeneration
☐ Lazy eye	☐ Dry eye	☐ Retinal disorder
☐ Eye turn	☐ Trauma	☐ Eye Inflammation

Eye Prosthesis: ☐ None ☐ Right Eye ☐ Left Eye

OCULAR SURGICAL HISTORY

PK Surgery	☐ NO	☐ YES	_____
LASIK Surgery	☐ NO	☐ YES	_____
PRK Surgery	☐ NO	☐ YES	_____
Cataract Surgery	☐ NO	☐ YES	_____
Pterygium Surgery	☐ NO	☐ YES	_____
Glaucoma Laser	☐ NO	☐ YES	_____
Glaucoma Tube Shunt Placement	☐ NO	☐ YES	_____
Glaucoma Trabeculectomy	☐ NO	☐ YES	_____
Retinal Injections (for Macular Degener.)	☐ NO	☐ YES	_____
Retinal Injections (for Diabetic Retinopathy)	☐ NO	☐ YES	_____
Retinal Laser	☐ NO	☐ YES	_____
Retinal Detachment Repair	☐ NO	☐ YES	_____
Oculoplastic Surgery (please select/circle)	☐ NO	☐ YES	_____

Blepharoplasty / Ptosis / Ectropion / Entropion / DCR / MOHS

Other: _____

CARDIOVASCULAR HISTORY

Heart Attack	☐ NO	☐ YES	_____
Cardiac Catheterization	☐ NO	☐ YES	_____
Cardiac Stent	☐ NO	☐ YES	_____
Bypass/CABG	☐ NO	☐ YES	_____
Pacemaker	☐ NO	☐ YES	_____
Automatic Internal Defibrillator (AICD)	☐ NO	☐ YES	_____
Congestive Heart Failure	☐ NO	☐ YES	_____
Arrhythmia (Afib, Aflutter, etc)	☐ NO	☐ YES	_____
Coronary Artery Disease	☐ NO	☐ YES	_____
Valvular Heart Disease	☐ NO	☐ YES	_____
Hypertension/High Blood Pressure	☐ NO	☐ YES	_____
High Cholesterol	☐ NO	☐ YES	_____

Other: _____

RESPIRATORY HISTORY

COPD	☐ NO	☐ YES	O2 Saturation:	_____
Tuberculosis	☐ NO	☐ YES		
Sleep Apnea	☐ NO	☐ YES	☐ CPAP	☐ BIPAP
Emphysema	☐ NO	☐ YES		
Continuous Oxygen	☐ NO	☐ YES	O2 Saturation:	_____
			# L/min:	_____
Asthma	☐ NO	☐ YES		
Shortness of Breath	☐ NO	☐ YES		
Chronic Cough	☐ NO	☐ YES		

Other: _____

NEUROLOGICAL HISTORY

Stroke/TIA	☐ NO	☐ YES	_____
Alzheimer's	☐ NO	☐ YES	_____
Parkinson's	☐ NO	☐ YES	_____
Dementia	☐ NO	☐ YES	_____
Multiple Sclerosis	☐ NO	☐ YES	_____
Epilepsy/Seizures	☐ NO	☐ YES	_____
Restless Leg Syndrome	☐ NO	☐ YES	_____
Headaches	☐ NO	☐ YES	_____
Migraines	☐ NO	☐ YES	_____
Vertigo	☐ NO	☐ YES	_____

Other: _____

HEMATOLOGICAL HISTORY

Hepatitis	☐ NO	☐ YES	Type: _____
Blood Clots	☐ NO	☐ YES	_____
Bleeding Tendencies	☐ NO	☐ YES	_____
Blood Thinners	☐ NO	☐ YES	_____
Anemia	☐ NO	☐ YES	_____
Blood Transfusions	☐ NO	☐ YES	Year: _____

Other: _____

MISCELLANEOUS HISTORY

Diabetes	☐ NO	☐ YES	Type: _____
Dialisys	☐ NO	☐ YES	When: _____
Malignant Hyperthermia	☐ NO	☐ YES	
Organ Transplant	☐ NO	☐ YES	Type: _____
Sjogren's Syndrome	☐ NO	☐ YES	
Rheumatoid Arthritis	☐ NO	☐ YES	
Lupus	☐ NO	☐ YES	

Patient Signature: _____ Date: _____

If Patient is a minor, Parent/Guardian Signature: _____

MEDICATION & ALLERGY CHART

Name: _____ DOB: _____ Acct #: _____

MEDICATIONS LIST

Medications / Supplements	Dosage	Frequency

☐ *See Attached List*

ALLERGIES

Allergen	Reaction

Patient Signature: _____ Date: _____

If Patient is a minor, Parent/Guardian Signature: _____

Name: _____ DOB: _____ Acct #: _____

CATARACT QUESTIONNAIRE

Do you have difficulty, even with glasses, with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

2. Reading a newspaper or book? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

3. Seeing steps, stairs or curbs? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

4. Reading traffic signs, street signs or store signs? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

5. Doing fine handwork like sewing, knitting, crocheting or carpentry? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

6. Writing checks or filling out forms? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

7. Playing games such as bingo, dominos, card games or mahjong? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

8. Watching television? ☐ Yes ☐ No ☐ N/A

If yes, how much difficulty do you currently have? ☐ A little ☐ A moderate amount ☐ A great deal ☐ Unable to do the activity

Patient Signature: _____ Date: _____

If Patient is a minor, Parent/Guardian Signature: _____

Name: _____ DOB: _____ Acct #: _____

What is (or was) your occupation? _____

LIFESTYLE QUESTIONS
TELL US ABOUT YOU

Understanding your lifestyle and the activities you enjoy can help us recommend the kind of cataract surgery that will provide you with clearer vision and less dependence on glasses.

Please select the following activities you do on a regular basis:

Distance Vision

- ☐ Driving - daytime
- ☐ Driving - nighttime
- ☐ Golfing / Other sports
- ☐ Watching movies / Going to theater
- ☐ Viewing scenery / Taking photographs
- ☐ Other:

Intermediate Vision

- ☐ Seeing car dashboard
- ☐ Using computer
- ☐ Using tablet
- ☐ Shopping
- ☐ Playing cards
- ☐ Other:

Near Vision

- ☐ Reading books / newspapers
- ☐ Doing crossword puzzles
- ☐ Using cell phone
- ☐ Sewing / Needlepointing
- ☐ Applying makeup
- ☐ Other:

Are you having any difficulty with the following with your current vision?

☐ Bright daylight ☐ Nighttime streetlights / headlights ☐ Reading

Please place an "X" on each continuum where it best describes how you feel about the following:

	I want to wear glasses	I don't want to wear glasses
Correction of near vision: (e.g., reading, use of phone)	☐	
Correction of intermediate vision: (e.g., using a tablet/computer)	☐	
Correction of distance vision: (e.g., driving, watching television)	☐	

Your doctor will discuss the advantages and disadvantages of the various options for cataract surgery. Please indicate how knowledgeable you are about your cataract surgery options:

☐ Not knowledgeable ☐ Somewhat knowledgeable ☐ Knowledgeable

Which of the following best describes your personality type?

☐ Easygoing ☐ Flexible ☐ Organized / Planner ☐ Perfectionist

Your signature: _____ Date: _____

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REFRACTION POLICY

Medicare, HealthSprings, Medicaid, Blue Cross Blue Shield plans along with many other medical insurance plans **WILL NOT** cover the charge for a **Refraction** (a test determining your actual vision perception).

If this test is performed during your exam today, payment of **$45.00** will be collected from you.

I have been made aware by Cool Springs Surgical Associates of their policy regarding a refraction and agree to pay the current charge of $45.00.

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Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Operations (HIPAA)

I understand that my health information is private and confidential. I understand that the Physicians and staff members of Cool Springs Surgical Associates (further the Practice) work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that the Practice may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

the Practice have provided a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

The Practice may update this "Notice of Privacy Practices". If I ask, their office will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask the Practice to restrict how my personal health information is used or disclosed to carry our treatment, payment, or health care operations. I understand that the Practice does not have to agree to my request, I understand that the Physicians and staff members would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that the Practice may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that the Practice can give me called "Revocation of Consent for Use and Disclosure of Health Care Information", or
2. Writing, signing, and dating a letter to the Practice. If write a letter, it must say that. I want to revoke my consent to authorize use and disclosure of the patient's personal health information for treatment, payment and health care operations.

I understand if I cancel this consent, the Practice does not have to provide health care services to me. Please answer the questions below concerning your Protected Health Information:

Can we call you at home:	☐ YES	☐ NO
Can we leave a message on your answering machine if you have one:	☐ YES	☐ NO
Can we discuss your clinical results with someone else:	☐ YES	☐ NO

If YES, please list their name(s): _____

Can we call your place of work:	☐ YES	☐ NO
Can we leave a message for you at your place of work:	☐ YES	☐ NO

If you would like a copy of the Practice's "Notice of Privacy Practices" just ask our receptionist who will be glad to provide you with a copy. Your signature below indicates that you have been given the chance to review a current copy of the Practice's "Notice of Privacy Practices".

Patient Signature: _____ Date: _____

If Patient is a minor, Parent/Guardian Signature: _____

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Name: _____ DOB: _____ Acct #: _____

PATIENT FINANCIAL RESPONSIBILITY CONSENT

Assignment of Insurance Benefits Up to Amount of Medical Service: In consideration of medical and other healthcare services to be rendered (the "Medical Services") to me (or to the patient, if I am the guarantor thereof) by **Cool Springs Surgical Associates** or any of its affiliates entities' it controls, is controlled by, or any of its common control with (collectively, Cool Springs Surgical Associates), I, the undersigned patient (or guarantor of the patient signed below) hereby assign and transfer, and authorize to be assigned and transferred, to Cool Springs Surgical Associates any benefits payable to or for patient's benefits under any health, medical, hospitalization, or other insurance coverage for payment of the Medical Services. This assignment of benefits is irrevocable and extends to the total amount owed by me to Cool Springs Surgical Associates from time to time. I hereby certify that the insurance and other information that I have provided Cool Springs Surgical Associates is true and accurate as of the date(s) the Medical Service are to be performed and that I am responsible for keeping such information updated. I am fully aware that having health insurance does not absolve me (and the patient, if I am the guarantor) of my responsibility to ensure that the medical bills for the Medical Service are paid in full. I also understand that my insurance company (as term is defined below) might not pay 100% of the amount billed by Cool Springs Surgical Associates for the Medical Services.

I AGREE TO PAY FOR ANY AND ALL AMOUNTS CHARGED BY COOL SPRINGS SURGICAL ASSOCIATES FOR MEDICAL SERVICES WHICH COOL SPRINGS SURGICAL ASSOCIATES HAS NOT RECEIVED PAYMENT FOR FROM MY INSURANCE COMPANY WITHIN FORTY-FIVE (45) DAYS OF CATARACT & EYE CARE'S PROVISION OF THE MEDICAL SERVICES.

Insurance companies reimbursement on a fee schedule, which may bear no relationship to the current standard and cost of care in the area. I hereby agree to cooperate with Cool Springs Surgical Associates to obtain necessary authorizations from my Insurance Company or other insurers.

Authorization to Submit Insurance Claims: I hereby authorize Cool Springs Surgical Associates to submit claims, on behalf to my insurance company (the "Insurance Company(s)") listed on the copy of the current insurance card(s) I have provided Cool Springs Surgical Associates, which I represent I have provided to Cool Springs Surgical Associates "in good faith" and which I represent provides current medical coverage for the contemplated Medical Services. I fully agree and understand that the submission of a claim does not absolve me (or the patient, if I am the guarantor) of my responsibility to ensure the claim is paid in full. If benefits cannot be determined, benefits are denied, and/or when there is any doubt of coverage, I hereby acknowledge that full payment for the Medical Services is due at the time of my appointment. Cool Springs Surgical Associates preferred method of payment is cash; however, we will accept personal checks, debit cards, MasterCard, Discover, American Express and Visa.

Limited Attorney-in Fact to Obtain Payment and Patient Information: I hereby irrevocably designate, authorize and appoint Cool Springs Surgical Associates as my true and lawful personal representative and attorney-in-fact for the limited purpose of performing all acts, deeds, matter and things, as I might or could do in my own proper person, if personally present, related to (a) my relationship with my Insurance Company(s), (b) obtaining payment from my Insurance Company(s) with regard to the Medical Services, and (c) obtaining information related to the Medical Services and my benefits from my Insurance Company(s). The powers granted to Cool Springs Surgical Associates herein include, but are not limited to, the power to (i) receive any and all payments for the Medical Services from my Insurance Company(s) or other third parties, (ii) submit and receive any and all requests for benefits information from my Insurance Company(s), (iii) request, receive, and review any and all applicable plan documents or other information from my insurance company(s) or other third parties, (ii) submit and receive, and review any and all applicable plan documents or other information from my Insurance Company(s)concerning me, (iv) purse all remedies as to claims as to the Medical Services with or against my Insurance Company(s) including, but not limited to, formal complaints, appeals, administrative review or litigation to any State or Federal agency, insurance board or insurance company that has jurisdiction over benefits that are or may be available to pay for all or part of the Medical Services, and (v) request and receive any and all information from my Insurance Company that I am entitled. This power of attorney shall automatically terminate, without formation action being taken by my attorney-in-fact pursuant to the authority granted herein.

ERISA Authorization: I hereby authorize and direct my Insurance Company(s) to assign and transfer any applicable ERISA plan benefits and right to Cool Springs Surgical Associates including the right to receive any applicable plan documents and/or remedies, and to pursue appeals, administrative reviews or litigation on my behalf.

Direct Payment Authorization: I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY(S) TO PAY COOL SPRINGS SURGICAL ASSOCIATES DIRECTLY, I UNDERSTAND THAT I HAVE THE RIGHT AND AUTHORITY TO DIRECT WHERE PAYMENT FOR SERVICES RENDERED IS SENT. If my current insurance policies with my Insurance Company(s) prohibit direct payment to the provider of services, I (under my rights per State and Federal regulations) hereby instruct and direct my Insurance Company(s) to provide supporting documentation evidencing the existence of such non-assign ability clause to myself and to Cool Springs Surgical Associates. Upon receipt by Cool Springs Surgical Associates of the non-assignability documentation, I instruct the Insurance Company(s) to make out the check to me (or the patient, if I am the guarantor) and mail such check directly to: Cool Springs Surgical Associates **3301 Aspen Grove Dr, Ste 201, Franklin TN 37067** as payment towards the total charges for the Medical Services rendered. We require that all checks be forwarded to our office no later than seven (7) dates from the dates from the date your insurance carrier issue the check. In the event my Insurance Company does not mail the check (made out to me) directly to Cool Springs Surgical Associates. I hereby agree to mail such check to Cool Springs Surgical Associates at the address above as soon as I receive it. I agree and understand that any funds I receive from my Insurance Company(s) due to me (or due the patient, if I am the guarantor) for the Medical Service will be immediately signed over by me and sent directly to Cool Springs Surgical Associates.

Check Deposit Authority: Whenever my Insurance Company(s) might send a check directly to me for the Medical Service provided by Cool Springs Surgical Associates or any of its affiliates, if I deposit such a check into an account other than Cool Springs Surgical Associates or its affiliates, I agree to send Cool Springs Surgical Associates or its affiliates a payment for the equivalent amount. If I receive from any Insurance Company, Medicare or Medicaid, and Explanation of Benefits (EOB), I agree to send a copy of such immediately to Cool Springs Surgical Associates or its affiliates. Upon receipt by Cool Springs Surgical Associates or its affiliates of any and all checks made payable to me or patient, I authorize Cool Springs Surgical Associates or its affiliates to receive such check, endorse it for deposit it and to apply all proceeds toward payment on my account for the Medical Services.

Copays: I hereby agree to, at the time the medical services are rendered, pay all copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by my Insurance Company.

Attorney Fees: If my account with Cool Springs Surgical Associates is referred to an attorney or outside agency for collection, I agree to pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the maximum legal rate. I understand and agree that if my account is delinquent, I may be charged a service fee.

Consent to Credit Report: I agree to allow Cool Springs Surgical Associates to obtain my credit report from a credit reporting agency chosen by Cool Springs Surgical Associates. I hereby authorize such credit reporting agency and Cool Springs Surgical Associates to obtain information regarding my employment, my accounts, and outstanding credit accounts. I hereby authorize such credit reporting agency to release a copy of my credit application.

Release of Medical Records to Obtain Coverage: I authorize the release of any medical or other information reasonable necessary to determine benefits available or benefits payable by my insurance company(s) or for the purpose of satisfying charges billed by Cool Springs Surgical Associates for Medical Services to my Insurance Company(s) or other entities, if requested. I hereby release and forever discharge Cool Springs Surgical Associates and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives from any and all obligations, claims, liabilities, damages, debt, liens, and deficiencies arising out of or in connection with Cool Springs Surgical Associates use or disclosure of my health information.

Miscellaneous: A photocopy of this document shall be considered as effective and valid as the original. For checks returned to Cool Springs Surgical Associates for non-sufficient funds by your bank, Cool Springs Surgical Associates will charge $30.00 fee per returned check.

Patient's Name: **Tester Test**

Patient / Guarantor's Signature: _____

Witness Name:

Witness Signature: _____

Date: _____