Drs. Campbell Cunningham
Taylor & Haun

Dear Valued Patient!

We appreciate your continued patronage. In order to serve you more efficiently and to ensure that your insurance is filed correctly, the following information is needed.

1) **PLEASE COMPLETE THE ENCLOSED INFORMATION SHEET AND REVIEW OF SYSTEMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.**

2) Many insurance companies now require a referral authorized by your primary care physician before you can see a specialist. If your insurance company requires a referral, please take the steps necessary to obtain the referral prior to your appointment date. We will **NOT** be able to see you without the referral if your insurance company requires one.

3) Bring all medical insurance cards with you to your appointment. Please be prepared to pay your co-pay if your insurance has one. If you have questions regarding your insurance or referrals, please contact our referral coordinator, at ext. 109.

4) Please note: If you are refracted and receive a glasses prescription there will be a $30.00 refraction fee. This is not covered by insurance, please be prepared to pay.

IF YOUR INSURANCE CARD LOOKS LIKE THIS

YOU DO NOT NEED A REFERRAL:

HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN DOE

CLAIM NUMBER
111-11-1111A

SEX
MALE

IS ENTITLED TO
MEDICAL BENEFITS **01-01-01**
HOSPITAL BENEFITS **01-01-01**

EFFECTIVE DATE

SIGN HERE ➡ _____

*YOU MUST HAVE PART B OR MEDICAL BENEFITS IN ORDER FOR US TO FILE YOUR MEDICAL CLAIMS.

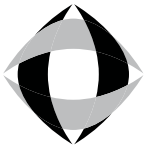
Knoxville (Main Office)
1124 East Weisgarber Road
Suite 100
Knoxville, TN 37909
(865) 584-0905
Fax (865) 584-3892

Farragut
12744 Kingston Pike
Suite108
Knoxville, TN 37934
(865) 934-1700
Fax (865) 392-5533

Maryville
628 Smithview Drive
Maryville, TN 37803
(865) 984-7012
Fax (865) 981-4401

Sevierville
962 Dolly Parton Parkway
Sevierville, TN 37862
(865) 428-8000
Fax (865) 428-2091

Patient
Information



DRS. CAMPBELL CUNNINGHAM
TAYLOR & HAUN

PATIENT INFORMATION SHEET

Last Name _____ First Name _____ MI ___ Address (No PO Box) _____

City _____ State _____ Zip _____ Sex _____ Marital Status_____

Date of Birth _____ E-Mail Address _____ Social Security # _____

Cell Phone # _____ Phone # _____ Employer _____

Employer Phone # _____ Ethnicity ☐ Asian ☐ Black ☐ Caucasian/White ☐ Hispanic ☐ Other?

INSURANCE INFORMATION: PLEASE PROVIDE CARDS AND PHOTO ID

Primary Insurance _____

Secondary Insurance _____

Pharmacy Name _____ Phone # _____

Do you have a living will? YES____ NO____ Power Of Attorney? YES____ NO____

NEW PATIENTS PLEASE COMPLETE / EXISTING PATIENTS IFORMATION HAS CHANGED:

Spouse / Guardian Name _____ SSN#_____

Spouse / Guardian Employer _____ Employer Phone Number#_____

Spouse / Guardian DOB _____

EMERGENCY INFORMATION: PERSON OR NEAREST RELATIVE TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone # _____

WHO REFERRED YOU TO OUR PRACTICE?

☐ Friend / Relative ☐ Internet ☐ Other ☐ Doctor (Doctor's Name) _____

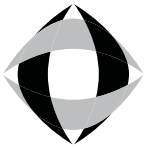
Financial Policy and Non-Covered Services

Drs. Campbell Cunningham Taylor & Haun

We are dedicated to providing our patients with the highest quality ophthalmic care and to runnning our clinic efficiently. Please assist us in achieving these goals by complying with our financial policy. Payment is due at the time the service is provided. It is your responsibility to verify insurance and determine the status of coverage (co-pay and deductible) prior to your visit.

Forms of Payment	Cash, check, major credit card or payment plan.
Co-Pays and Deductibles	All Medicare, Medicaid, and other insurance pan co-pays and deductibles are payable upon Check-Out. It is your responsibility to know your portion payable at the time of service.
Medicare	We accept assignment and will file all Medicare claims. At the time of service you are responsible for 20% of the Medicare allowable fee, plus the deductible and any service charge not covered by Medicare (details on back). Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(l) of the Medicare law. If Medicare denies payment, by signing you agree to be personally and fully responsible for payment. You also agree that payment of authorized Medicare/Medigap benefits be made payable to Drs. Campbell, Cunningham, Taylor & Haun for services rendered by that physician/supplier. Your signature will also authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.
Medicaid	A current copy of the Medicaid card is required prior to treatment or the patient will be rescheduled.
Workers Comp	Workers Compensation authorization is required prior to the appointment.
Private Ins and Managed Care	If you participate in a plan that we accept we will be happy to file your insurance claims for you. Otherwise payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment.
Self-Pay	Payment is expected at Check-In prior to being seen by the doctor. You may call our office for an estimate of our fees. Any refund or balance due will be calculated at the Check-Out If you are not prepared to cover our exam, then we can offer you coverage through a payment plan or reschedule your appointment.
Non-Covered Services	Several non-covered services are essential for the physician to properly evaluate and treat you during your eye exam. They include Refraction, Corneal Topography, Corneal Cell Check, Surgery kits, etc. Medicare and most insurance plans do not cover these fees which will be payable upon Check-Out. You may choose to defer these or any services.
Drivers Form	We will be happy to complete a Drivers' Form for you for a nominal fee.
Other Forms	For any additional insurance forms or dictated letters from our doctors, a nominal fee per form will be charged. Documents will be ready in 2-3 business days.
Other Information	Any check returned to our office for non-payment will generate an additional processing fee. We can assist you with setting up a payment plan in order to pay an outstanding balance. Accounts turned over to a collection agency will also incur an administrative fee as well as any additional fees associated with that effort, uncluding court costs.
Refunds	Credit balances uder $50.00 will remain as a credit on our account to be applied to your next visit unless a refund is requested.

Patient Authorization to Disclose Protected Health Information & Acknowledgement of Privacy Practices



Drs. Campbell Cunningham
Taylor & Haun

Patient's Name: _____ Chart #: _____ Date: _____

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Drs. Campbell, Cunningham, Taylor & Haun. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

• I hereby authorize Drs. Campbell , Cunningham , Taylor & Haun to release to my insurance companies &/or their intermediaries and/or carriers any medical or other information needed for claims reimbursement.
• I hereby assign, transfer, and set over to Drs. Campbell, Cunningham, Taylor & Haun all medical reimbursement benefits under my insurance policy with above documented insurance companies.
• I hereby acknowledge and accept responsibility for payment in full of all non-covered services rendered to me by Drs. Campbell, Cunningham, Taylor & Haun.

ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Campbell, Cunningham, Taylor & Haun for any service furnished to me by a physician of the group. l authorize any holder of medical information abbut me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. ln Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.**

MEDIGAP OR OTHER SECONDARY INSURANCE

l request that the payment of authorized Medigap benefits be made either by me or on my behalf to Drs. Campbell, Cunningham, Taylor & Haun, or any physician of t hat group, for services provided to me by a physician of the group. l authorize any holder of medical information about me to release it to my Medigap insurer or any information needed to determine these benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

_____ _____
Date *Signature of Patient/Guardian*

HIPAA Privacy Rule gives you tha patient the right to request restrictions on uses and disclosures of your Protected Health Information (PHI). You also have the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed. Drs. Campbell, Cunningham, Taylor & Haun have my authorization to contact me in the following manner:

Home Telephone # _____

☐ O.K. to leave message with detailed information
☐ Leave message with call back number only
☐ Please only leave a message with _____ _____
Contact Person's Name *Relationship*

Work Telephone # _____

☐ O.K. to leave message with detailed information
☐ Leave message with call back number only
☐ Other _____

Written Communications

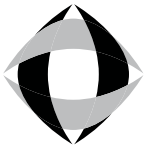
☐ O.K. to mail to my home address
☐ O.K. to fax to this number _____

_____ _____
Patient Initials *Date*

I hereby acknowledge reading Notice of Privacy Practices and understand that I have the right to obtain a paper copy of this notice:

_____ _____
Date *Signature Of Patient / Guardian*

Medical History



Drs. Campbell Cunningham
Taylor & Haun

Name _____ Date _____

Chart # _____ Primary Care Doctor _____

REVIEW OF SYSTEMS

Do you have a problem with any of the following? Please circle Yes or No.

Constitutional - Weight Loss/Gain, Fever	**Yes**	**No**
Ear, Nose, Throat, Mouth - Sinus	**Yes**	**No**
Cardiovascular - Hear, High Blood Pressure	**Yes**	**No**
Respiratory - Lung, Breathing, Asthma, TB	**Yes**	**No**
Gastrointestinal - Stomach, Intestines, Hepatitis	**Yes**	**No**
Genitourinary - Gential, Kidneys, Bladder	**Yes**	**No**
Musculoskeletal - Arthritis, Muscle, Joints	**Yes**	**No**
Integumentary - Skin	**Yes**	**No**
Neurological / Psychiatric - Depression, Nerves, MS	**Yes**	**No**
Endocrine- Diabetes, Thyroid	**Yes**	**No**
Hematologic / Lymphatic- Anemia, Bleeding Tendency	**Yes**	**No**
Allergic / Immunologic - Lupus, Sjogrens, HIV	**Yes**	**No**
Other - Cancer, Stroke, Etc.	**Yes**	**No**

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE MEDICATION)

_____ _____

_____ _____

_____ _____

_____ _____

Please list any allergies to medication: _____

OCULAR HISTORY

Have you ever been diagnosed with any of the following?

Cataracts	**Yes**	**No**	Cornea Disease	**Yes**	**No**
Crossed Eyes	**Yes**	**No**	Glaucoma	**Yes**	**No**
Retina / Macular Disease	**Yes**	**No**	Other Eye Disorders	**Yes**	**No**

EYE SURGERIES

Cataract: (Date OF Surgery) R_____ L_____

Retina: (Date OF Surgery) R_____ L_____

EYE INJURIES

_____

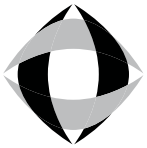
_____

FAMILY & SOCIAL HISTORY

Do any of your family members have the following?

Glaucoma	**Yes**	**No**	Diabetes	**Yes**	**No**
Cataracts	**Yes**	**No**	Heart Problems	**Yes**	**No**
Stroke	**Yes**	**No**	Cancer	**Yes**	**No**
Retinal Detachment	**Yes**	**No**	Retina / Macular Disease	**Yes**	**No**

Medical History



Drs. Campbell Cunningham
Taylor & Haun

Your Information

Patient Name _____ Chart# _____ Today's Date: _____

Review of Systems—Do you have a problem with any of the following? Please circle YES or NO.

1. Constitutional—Weight Loss/Gain, Fever: ..... Yes ☐ No ☐
2. Ear, Nose, Throat, Mouth—Sinus ..... Yes ☐ No ☐
3. Respiratory—Lung, breathing, asthma, TB: ..... Yes ☐ No ☐
2. Gastrointestinal—Stomach, Intestines, Hepatitis—Sinus ..... Yes ☐ No ☐ Diagnosis date:
   a. Diabetes ..... Yes ☐ No ☐ _____
      Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐ _____
      Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐ _____
   b. Heart attack ..... Yes ☐ No ☐ _____
      Angina or chest pain ..... Yes ☐ No ☐ _____
      Heart failure ..... Yes ☐ No ☐ _____
      Irregular or rapid heart beat ..... Yes ☐ No ☐ _____
      Cardiac pacemaker inserted ..... Yes ☐ No ☐ _____
   c. High blood pressure ..... Yes ☐ No ☐ _____
   d. Stroke or TIA ..... Yes ☐ No ☐ _____
   e. Anemia ..... Yes ☐ No ☐ _____
   f. Asthma ..... Yes ☐ No ☐ _____
      Emphysema and/or bronchitis ..... Yes ☐ No ☐ _____
      Pneumonia ..... Yes ☐ No ☐ _____
      Tuberculosis ..... Yes ☐ No ☐ _____
   g. Liver disease or jaundice ..... Yes ☐ No ☐ _____
   h. Stomach or duodenal ulcer ..... Yes ☐ No ☐ _____
   i. Kidney stones / other kidney disease ..... Yes ☐ No ☐ _____
   j. Arthritis: rheumatoid ☐ osteo ☐ ..... Yes ☐ No ☐ _____
   k. Cancer or tumor ..... Yes ☐ No ☐ _____
      Type: _____
   Treatment: _____
   l. Thyroid disease: underactive ☐ overactive ☐ ..... Yes ☐ No ☐ _____
      Treatment: _____
   m. Migraine ..... Yes ☐ No ☐ _____
n. Blood clot in legs ..... Yes ☐ No ☐ _____
o. Bleeding disorders ..... Yes ☐ No ☐ _____
   p. Transfusions of blood or plasma ..... Yes ☐ No ☐ _____
q. HIV positive, AIDS ..... Yes ☐ No ☐ _____
   r. Other medical problems ..... Yes ☐ No ☐ _____
      Please describe: _____
4. Are you allergic to any medications or foods? ..... Yes ☐ No ☐ _____
   If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below: _____

Eye medication(s):				**All other medication(s):**		
Name	Dose	Frequency	Eye	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

What to Expect on Your First Visit.

Drs. Campbell Cunningham Taylor & Haun

If you have not already completed and mailed us the following forms, please bring them to your first appointment.

- Completed Medical History form
- Completed Patient and Billing Information form
- Signed Patient Acknowledgement of Privacy Practices form
- Any medications you are taking (including eye drops)
- Your insurance cards (including Medicare and Medicaid)
- Your driver's license or photo ID

CHECK-IN. Your forms will be collected at our reception and placed inside your file. We will make a photocopy of your insurance card and license.

WAITING TIME. Our goal is for our clinic to run on time, however, high demand and daily medical emergencies can result in delays. Generally, a comprehensive eye exam with dilation requires approximately one and a half to two hours. If you have urgent time restrictions, please let us know in advance.

INITIAL EVALUATION BY OPHTHALMIC TECHNICIAN. You will be taken to an assessment area where your vision will be evaluated. Once in the exam room, the ophthalmic technician will review your medical history and check your vision. Other tests may be performed based on your primary complaint and past medical history. The technician may use eye drops to dilate your pupils. Dilation may be necessary to completely examine your eyes. You will then be moved to our dilation waiting area for approximately 30 minutes while the drops take effect.

OPHTHALMOLOGISTS EXAM. Your eyes will be thoroughly examined by the doctor. Depending on the nature of your problem, we may perform additional tests on the day of your initial examination and, in some cases, treatment may be initiated.

Your vision will be temporarily blurred in bright light due to the dilation, so we strongly recommend that someone drive you after the examination. Your pupils and vision will return to normal over the next 24 hours.

Please do not hesitate to ask any questions about the results of your examination or the treatment recommended by the physician. Your diagnosis and all possible treatments will be completely explained to you.

CHECK-OUT. Our receptionist will review your routing slip and advise you of payment. We file all major insurance claims and accept cash, checks, major credit cards, and Care Credit. You will be asked to provide payment for co-pays, deductibles, non-covered items and uninsured services, such as the refraction fees.

Thank you for choosing Drs. Campbell, Cunningham, Taylor & Haun for your eye care needs. We are committed to serving your eye health. Please let us know if we can improve our service in any way.