Medical Notes ***STAFF USE ONLY***

_____

_____

_____

_____

_____

_____

_____

_____

OP = _____

PVS = _____

OSS = _____

TS = _____

Administrative Notes ***STAFF USE ONLY***

Amount	Method	Staff	OD / OS	Date

SURGICAL HISTORY

_____

_____

_____

_____

_____

_____

Name Mr. / Mrs. / Miss. / Dr. _____

DOB: _____ Age: _____ SS# _____ Nickname: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

Employer: _____ Occupation: _____

Work address: _____ City, State, Zip: _____

Insurance Information

Insurance Provider: _____

Insured's Name: _____ Date of Birth: _____ SS#: _____

Physician Information

Eye Doctor: _____ Phone: _____

Address: _____ City, State, Zip: _____

Primary MD: _____ Phone: _____

Address: _____ City, State, Zip: _____

Did your doctor refer you? ○ **Yes** ○ **No** **If yes, which doctor?** _____

What brought you to Wang Vision Institute?

Tennessean ○ Seminar ○ Web Site ○

Radio Ad / Station _____ TV Ad / Station _____

Previous Patient _____ Other _____

Your Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy Contact

Pharmacy Name: _____ Phone: _____ Fax: _____

Please read and sign the next page.

Wang Vision Payment Policy

□ Payment is required at the time of service for all cash pay patients. When medical services are covered by our accepted insurance plans, co-pays and deductibles will be collected at the time of service. All patients are responsible for payment of services rendered.

□ WVI is not responsible for knowing the status or details of your insurance coverage, or whether pre-certification, pre-approval, or referral is required for your insurance coverage to apply. This is your responsibility, and you will be responsible for services not reimbursed by your insurance.

□ We accept VISA, MasterCard, Discover, cashiers checks and personal checks (no third party checks). We do NOT accept American Express. Financing is available with outside programs, although we cannot guarantee approval.

□ While medical services are reimbursable by medical insurance in some circumstances, there are several types of visits that are not filed to insurance, and you will be responsible for these fees when services are provided:

- o Refractive Surgery evaluations, including LASIK, PRK and CK
- o Routine eye exams (although you can ask for paperwork to file yourself if you have vision insurance)
- o Second opinion evaluations for previous surgery, including but not limited to RK, AK, PRK, LASIK, Multi-focal lens implants and Intacs
- o Contact lens fittings and lenses
- o Refraction for glasses

By signing below, you acknowledge that you are financially responsible for all services, regardless of your intent to bill the insurance company for services rendered.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Authorization to discuss medical information with the follow:

Name: _____
Relationship to patient

Name: _____
Relationship to patient

Name: _____
Relationship to patient

Wang Vision Institute
Ming Wang, MD, PhD
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 Cataract and LASIK Institute which are not covered by my insurance carrier. I understand that insurance may not cover all of the fees involved during my treatment, possibly even those which my health care 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, PRK, CK, etc.
- Routine eye exams
- Second opinion evaluations after a previous refractive procedure, including, but not limited to: RK, AK, LASIK, PRK, Intraocular lens implants, Intacs, etc.
- Contact lens fittings
- Refractions for glasses
- Contact lenses and 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 Cataract and LASIK Institute, I acknowledge that I am financially responsible for payment in full for the fees associated with these services, and agree to make such payments by the date in which they are due.

_____ _____
Patient Signature Date

_____
Printed Name

Wang Vision Institute Paperless Billing Policy

In our effort to reduce paper waste, reduce overall healthcare costs and become more efficient, we are pleased to introduce Paperless Billing!

You will **no longer** need to receive paper statements or send payments through the mail.

How does this work?

If you have ever reserved a hotel room, you are already familiar with this process. The hotel collects your credit or debit card information when you check in, and authorizes your card for the amount they expect your final bill will be. The hotel then charges you for the actual amount you owe when you check out.

Just Six Easy Steps…

1. You will receive an estimated total including your insurance company's estimated payment and any discount you receive.
2. We will pre-authorize the estimated total on your credit/debit card.
3. We will submit your charges to your insurance company.
4. Your insurance company will send you an explanation of benefits (EOB), including the total out-of-pocket amount that you will owe for your visit.
5. Your insurance company will send us a copy of the EOB showing the amount you owe.
6. We will charge that amount to your credit/debit card. Your balance will now be paid without any hassle.

No Credit Card?

If you do not have a credit card, you can pre-pay your estimated bill when you check out. This pre-paid amount will be credited to your bill. Once your EOB arrives showing the amount you owe for the visit, it will automatically be deducted from your pre-paid amount. Any funds left over can be rolled over towards another visit or refunded to you. The pre-paid cash amount required is $100.

Patient Signature Date

FAMILY history (Living or Deceased) for the following medical conditions:

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

Social History (if applicable)

Do you drive? ○ yes ○ no

If yes, do you have visual difficulty when driving? ○ yes ○ no If yes, please describe:

_____

Do you use tobacco products? ○ yes ○ no If yes, type/amount/how long: _____

Do you drink alcohol? ○ yes ○ no If yes, type/amount/how long: _____

Do you use illegal drugs? ○ yes ○ no If yes, type/amount/how long: _____

Ocular History

Do you have dry eyes? ○ yes ○ no

If yes, characterize your symptoms: ○ mild ○ moderate ○ severe

Do you need readers/bifocals/progressive lenses? ○ yes ○ no

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

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

Do you sleep in them? ○ yes ○ no

List any eye surgery

Procedure:	Which eye:	Surgeon:	Date

Allergies to medication? ○ NO ○ YES	If YES, Please list medications: _____ _____

Wang Vision Institute

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Birth Date:_____ Last Medical Exam:_____ Last Eye Exam_____ Dr _____

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

Review of Systems

Have **YOU** currently or ever had any of the following?

SYSTEM	YES	NO	UNSURE	MEDICATIONS
INTEGUMENTARY (skin)	○	○	○	_____
EYES				
Loss of Side Vision	○	○	○	_____
Double Vision	○	○	○	_____
Dryness/Redness	○	○	○	_____
Flashes/Floaters in Vision	○	○	○	_____
EARS, NOSE, MOUTH, THROAT _____	○	○	○	_____
VASCULAR				
Chest Pain	○	○	○	_____
High Blood Pressure	○	○	○	_____
Vascular Disease	○	○	○	_____
Cholesterol	○	○	○	_____
Heart stents/catheters	○	○	○	_____
RESPIRATORY				
Asthma/Bronchitis	○	○	○	_____
Emphysema	○	○	○	_____
COPD	○	○	○	_____
Sleep apnea	○	○	○	_____
GASTROINTESTINAL _____	○	○	○	_____
GENITOURINARY				
Genitals/Kidney/Bladder	○	○	○	_____
BONES/JOINT/MUSCLES				
Arthritis/Joint Pain	○	○	○	_____
NEUROLOGIC				
Headaches/Migraines	○	○	○	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	○	○	○	_____
Bleeding Problems	○	○	○	_____
ENDOCRINE				
Diabetes	○	○	○	_____
Thyroid/Other Glands	○	○	○	_____
PSYCHIATRIC				_____
Other_____	○	○	○	_____

Are you pregnant and/or nursing? ○ yes ○ no

Wang Vision
1801 West End Avenue, Suite 1150, Nashville, TN 37203
615/321-8881

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.

Wang Vision
1801 West End Avenue, Suite 1150, Nashville, TN 37203
615/321-8881

Notice of Privacy Practices for Protected Health Information

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
1801 West End Avenue, Suite 1150
Nashville, TN 37203

Wang Vision
1801 West End Avenue, Suite 1150, Nashville, TN 37203
615/321-8881

Notice of Privacy Practices for Protected Health Information

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.

Wang Vision
1801 West End Avenue, Suite 1150, Nashville, TN 37203
615/321-8881

Notice of Privacy Practices for Protected Health Information

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.

Wang Vision
1801 West End Avenue, Suite 1150, Nashville, TN 37203
615/321-8881

Notice of Privacy Practices for Protected Health Information

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
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
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) Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative (Printed) 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 the 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 3D Cataract and LASIK Center

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

Wang Vision is located at the corner of 18th Ave South and West End Ave, on the 11th floor of the Palmer Plaza 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 this link on our website:
http://www.wangvisioninstitute.com/mapus.html

Palmer Plaza Building
view from West End

DETAILED DRIVING DIRECTIONS:

From Smyrna, Murfreesboro, Chattanooga, Antioch (and surrounding cities)
Take 1-24 West to Nashville, take 1-40 West at the 1-40/1-24 split. Exit at 209-A (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right so you will be on 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 to Nashville. Exit at 209-A (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right so you will be on 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 Nashville, take 1-40 West at the 1-40/1-24 split. Exit at 209-A (Broadway), and turn left onto Broadway. At the Broadway/West End Ave split, stay to the right so you will be on 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 West End Ave toward downtown. Go past Centennial Park and Vanderbilt University. After you pass a BP gas station and an Arby's on the right, 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 to Nashville, then take 1-440 East. Take the first West End Ave exit, and make a left. At the next traffic light, make another left onto West End Ave. Go past Centennial Park and Vanderbilt University. After you pass a BP gas station and an Arby's on the right, turn right 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. Stay to the right and follow the signs for 1-65 toward Memphis. Proceed on the right and take 1-40 East toward Knoxville. Take the third exit (209-B, Broadway/Demonbreun). Get into the far right lane. Turn right onto Broadway. At the Broadway/West End Ave split, stay to the right so you will be on West End. Turn left onto 18th Ave South. ***See parking instructions on the other side of this page***.

From Madison, Gallatin, Louisville, KY (and surrounding cities)
Take 1-65 South. Stay to the right and follow the signs for 1-65 toward Memphis. Proceed on the right and take 1-40 East toward Knoxville. Take the third exit (209-B, Broadway/Demonbreun). Get into the far right lane. Turn right onto Broadway. At the Broadway/West End Ave split, stay to the right so you will be on 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 Palmer Plaza designated 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!

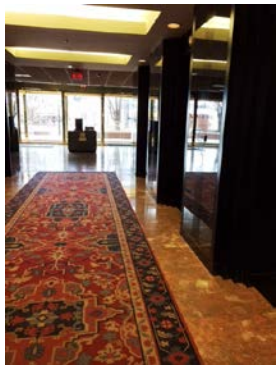
1) The entrance for the Palmer Plaza parking garage is on 18th Ave South, directly behind our building.


2) When you enter the garage, push the button to get a ticket, and **be sure to <u>bring your ticket up to our office so that we can validate it for you</u>**.

3) To enter the Palmer Plaza 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 one of the elevators, located to the right of the security desk, push floor 11.




6) You will see the entrance to Wang Vision right after you get off the elevator on the 11th floor. **Be sure to give your parking ticket to our staff to validate!**

7) After your Wang Vision visit, you will exit the garage at the same location you entered it (i.e., you do not need to go to one of the walk-up kiosks), and simply pull your car up to the gate arm, put your validated ticket into the designated slot, and the arm will go up so you can exit.