

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

Wang Vision 3D Cataract and LASIK Center
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 3D Cataract and LASIK Center 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 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, 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, 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 3D Cataract and LASIK Center, 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	SKELETOMUSCULAR	YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative disk disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Other skeletomuscular	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>			
DVT or PE (blood clot)	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL	YES	NO
Heart stents/surgery	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Other cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke or TIA (mini-stroke)	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	YES	NO	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Other respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>
			Other neurological	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL	YES	NO	ENDOCRINE	YES	NO
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Type 2 diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis of liver	<input type="checkbox"/>	<input type="checkbox"/>			
Other gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	YES	NO
			Depression	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY	YES	NO	Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease/failure	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Flomax	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Other genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Other psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
OTHER:	YES	NO	DRUG ALLERGIES (Include drug & reaction)	NONE <input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	

MEDICATIONS (INCLUDE DOSE & FREQUENCY):

FAMILY HISTORY (Living or deceased)

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

SOCIAL HISTORY

Do you drive? yes no

Are you pregnant or nursing? yes no

Tobacco use current past never Type: _____ Amount/day: _____ # of years: _____

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.

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

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.

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 Institute
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



WANG VISION
CATARACT & LASIK CENTER

Directions to Wang Vision 3D Cataract and LASIK Center

1801 West End Ave, 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 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>



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 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, Cookeville, 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. 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. 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 **1801 West End Ave.** designated parking garage (**the only guest entrance is on 18th Ave, behind the 1801 West End building**). **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!

<p>1) The entrance for the 1801 West End parking garage is on 18th Ave South, directly behind our building.</p> 	<p>2) When you enter the garage, push the button to get a ticket, and be sure to bring your ticket up to our office so that we can validate it for you.</p> 	<p>3) To enter the 1801 West End building, walk across the alleyway between the 2 structures (on the street level), or use the walkway (on the 2nd level of the garage).</p> 
<p>4) Enter the building.</p> 	<p>5) Walk a short distance to the elevators, and take one to the 11th floor.</p> 	<p>6) You will see the Wang Vision entrance as soon as you exit the elevator on the 11th floor. Be sure to give your parking ticket to our staff to validate!</p> 
<p>7) After your Wang Vision visit, you do not need to go to one of the walk-up kiosks if we validated your ticket in our office. You will need to exit the garage at the same location you entered it, i.e., all other exits are for building tenants only. Pull your car up to the gate arm, put your validated ticket into the designated slot, and the arm will go up allowing you to exit.</p>		