



OUR OFFICES ▪ 135 West Ravine Road, Suite 2C, Kingsport, TN 37660

PHONE (423) 246-7372 or (800) 688-EYES Switchboard Hours 7:30 to 4:30 Monday- Friday

OFFICE POLICIES & PROCEDURES

Welcome to The Regional Eye Center. Please review our office policies & procedures.

Appointments: In scheduling appointments, it is our intent to see you as soon as possible. We will also accommodate urgent **work-in appointments**. If you are experiencing problems / symptoms that need attention before your next regularly scheduled appointment, call the switchboard, choose the Triage Nurse telephone option, and leave the requested information. The Triage Nurse will return all calls in the order of their urgency.

On the day of your appointment:

- Bring your glasses, your current medications (prescription, over-the-counter, and nutritional supplements), your insurance cards, and a photo ID.
- It is important that we maintain current and accurate records on your behalf. Upon registration for each visit, you will be asked for any changes in your name, address, telephone number, and insurance coverage. It is your responsibility to ensure that updates are provided.
- During your visit, the doctor will review your medications, allergies, and medical conditions. It is your responsibility to keep us informed of any changes in your health status.
- If you cannot keep your appointment, notify our office at least 24 hours in advance so that we can make this time available for other patients.
- In the rare case that our office closes due to an unanticipated situation, someone will contact you to reschedule your appointment.
- Please refrain from cell phone conversations in clinical areas.

Prescription Refills: If you need a medication prescription refill, call during business hours. When calling the office, please choose the Triage Nurse telephone option and leave the requested information. Allow 24 hours for the refill to be called to your pharmacy although it usually does not take this long. Try to call a day or two before you expect your medication to run out so that you do not miss any regularly scheduled doses of your medication.

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Glasses Prescriptions: If you need a copy of your current glasses prescription, call during business hours, choose the Triage Nurse telephone option and leave the requested information. For specific questions involving our optical services, call our switchboard.

After-Hours Calls and Emergencies: If you call our switchboard after office hours, you will be instructed how to obtain urgent care. If you are calling for another service, you will be given other choices. If you have a medical emergency, go to the nearest hospital emergency room or call 911.

I have read and understand The Regional Eye Center Office Policies and Procedures.

Signature of Patient / Guardian

Date

Print Name of Patient / Guardian

General Consent to Treatment

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) authorize the physicians and staff of The Regional Eye Center to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose, and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and / or treatment.

Signature of Patient / Guardian

Date

Print Name of Patient / Guardian

The Regional Eye Center Authorized Signature

Date