



Personal Information

Mr. / Mrs. / Ms. / Dr.
Name: _____
DOB: _____ Age: _____
SS# _____ Nickname: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell: _____
Email: _____
Hobbies: _____

Employer: _____ Occupation: _____
Work address: _____ City, State, Zip: _____

DOCTOR'S NOTES: (please do not write in this space)

SURGICAL HISTORY

Date/Surgery/Eye

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?

- Flyer Seminar Bell South Yellow Pages Health Fair Web Site
- Yellow Book Yellow Pages Tennessean City Paper Dr. Wang's Reputation
- Radio Ad / Station _____ TV Ad / Station _____
- Previous Patient _____ Other _____

Your Emergency Contacts

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

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:
 - Refractive Surgery evaluations, including LASIK, PRK and CK
 - 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 Institute
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: ____/____/____
 Birth Date: ____/____/____ Last Medical Exam: ____/____/____ Last Eye Exam ____/____/____ Dr _____
 Name of Parent / Guardian (if Patient is a Minor): _____

Ocular History

How old were you when you first needed glasses? _____ Do you need readers/bifocals? yes no
 Describe any trouble with your glasses: _____
 Do you wear contact lenses? yes no How many years? _____ Date you discontinued CLs _____
 Type of CL: Soft Soft Toric Rigid Gas Permeable (RGP) Do you sleep in them? yes no
 Please check if you have any of the following:
 Double vision Glare Previous eye surgery Chronic Infections
 Unstable vision Foreign body sensation Eye injury Eye pain
 Other Please explain: _____
 Do you have dry eyes? yes no If yes, characterize your symptoms: mild moderate severe
 What are your goals/expectations after laser vision correction? _____

Are you interested in a complementary BOTOX® consultation during your refractive surgery evaluation? yes no

Medical History

Do you have any allergies to medications? yes no If yes, explain: _____
 List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____
 List all major injuries, surgeries and/or hospitalizations you have had: _____
 Are you pregnant and/or nursing? yes no
 List any eye surgery (procedure, which eye, date) _____

Please note any history (SELF, parents, grandparents, siblings, and/or children, living or deceased) for the following medical conditions:

<u>DISEASE/CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>UNSURE</u>	<u>SELF OR RELATIONSHIP TO YOU</u>
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"/>	_____
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 (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: _____

***Please turn this form over and complete the other side. ***

Review of Systems

Do you currently (or have you ever had) any problems in the following areas: (If YES, please explain and list medications.)

SYSTEM YES NO UNSURE EXPLAIN/MEDICATIONS

INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC				
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES				
Loss of/Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness/Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching/Burning/Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				
Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				
Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY				
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES/JOINT/MUSCLES				
Arthritis/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE				
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list all eye surgeries below:

Date	Procedure Performed	Which Eye?	Surgeon's Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

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

WANG VISION INSTITUTE AND LASER MEDSPA
Lifestyle Questionnaire

Name: _____

Date: _____

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle.

- Do you wear glasses now? No Yes If Yes: All the time / Sometimes
- How important is it for you to read or use computer without glasses?
Very Important / Important / Not Important
- How many hours per day do you: Read: _____ Use the Computer: _____
- Where do you hold book when reading? Close to face / Chest level / In your lap
- How do you *feel* about wearing glasses? _____
- If possible, would you like to go without glasses for most of the time? No Yes
- Do you drive at night? No Yes If Yes: Occasionally / Nightly / Profession (truck, taxi, bus)

Check the following activities you do on a regular basis:

- | | | | |
|---|--|--|-------------------------------|
| <input type="checkbox"/> Read newspaper, books | <input type="checkbox"/> Read medicine bottles | <input type="checkbox"/> Sewing/Needlework | |
| <input type="checkbox"/> Drive daytime | <input type="checkbox"/> Hunt or Fish | <input type="checkbox"/> Paint / Artist | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Drive nighttime | <input type="checkbox"/> Paperwork / Writing | <input type="checkbox"/> Tennis | <input type="checkbox"/> Cook |
| <input type="checkbox"/> Musician | <input type="checkbox"/> Play Cards / Dominos | <input type="checkbox"/> Bicycle | <input type="checkbox"/> Shop |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Photography | |
| <input type="checkbox"/> Spectator Sports | <input type="checkbox"/> Theatre | <input type="checkbox"/> Restaurant | |
| <input type="checkbox"/> Other, please specify: _____ | | | |

NEXT: Underline the above activities that you would like to do without glasses if possible.

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

Cosmetic Issues of Interest (please check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> Latisse for Longer Eyelashes | <input type="checkbox"/> Juvederm for “parenthesis” around lips |
| <input type="checkbox"/> Forehead wrinkles | <input type="checkbox"/> Frown lines between the eyes, known as “11’s” | <input type="checkbox"/> Crows feet |
| <input type="checkbox"/> Other, please specify: _____ | | |

Have you previously received any treatments listed above? Yes No
If so, which treatment(s)? _____
Approximate Dates? _____

How satisfied were you with your results? Very Satisfied / Somewhat Satisfied / Unsatisfied

Patient's Signature: _____

Tech Initials: _____



laser medspa

**We're located at 1801 West End Avenue (in the Palmer Plaza Building)
Suite 1150 (on the 11th Floor)
Nashville, TN 37203**

Phone: 615.321.8881 • Fax 615.321.8874

www.wangvisioninstitute.com • drwang@wangvisioninstitute.com

Parking is located behind the building.



From Southeast of Nashville (Smyrna, Murfreesboro, Chattanooga, and Antioch)

I-24 West to Nashville, West on I-40 at the I-40/I-24 split. Proceed to exit 209-A (Broadway exit) and turn left onto Broadway and at the Broadway/West End Avenue split in the road, go to the right. Turn left onto 18th Avenue. The building and parking garage are on the right.

From East of Nashville (Airport, Mt. Juliet, Lebanon, Cookville, and Knoxville)

I-40 to Nashville. Take exit 209-A (Broadway exit), then follow the directions above.

From South of Nashville (Brentwood, Franklin, and Huntsville, AL)

I-65 North to Nashville, then West on I-440 toward Memphis. Take the West End exit (East). Go past Centennial Park and Vanderbilt University. You will see a BP and an Arby's on the right. Turn right onto 18th Avenue (past Arby's). The building and parking garage are on the right.

From Southwest (West End, Bellevue)

Come up West End Avenue toward downtown Nashville and follow the directions above.

From Southwest and West of Nashville (Dickson, Jackson, and Memphis)

I-40 East to Nashville, then East on I-440. Exit the first West End Avenue exit, and make a left. At the next light make another left onto West End Avenue, then follow the directions from the South.

From Northwest of Nashville (Clarksville and Paducah, KY)

I-24 East to I-65 South to Nashville. Stay to the right and follow the signs for I-65 toward Memphis. Proceed on the right and take I-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 Avenue split in the road, go to the right. Turn left onto 18th Avenue. The building and parking garage are on the right.

From North of Nashville (Madison, Gallatin, and Louisville, KY)

I-65 South to Nashville and follow the directions from the Northwest of Nashville.