Georgia Ophthalmologists

Last:_____ First: _____ Preferred name_____ Sex: Male___ Female___

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Can we leave a message at the numbers above? Home: Yes__ No __ Work: Yes__ No__ Cell: Yes__ No__

Marital Status: _____ SS #: _____ Date of Birth: _____

Referring Physician or Family Doctor: _____

City: _____ State: _____ Office Tel #: _____

Primary Medical Insurance	**Secondary Insurance**
Insurance Company: _____	Insurance Company: _____
ID #: _____	ID #: _____
Subscriber's Name: _____	Subscriber's Name: _____
SS#: _____ DOB: _____	SS#: _____ DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

Do you have a Vision Plan (VSP, EYEMED, etc)? Yes ___ No ____

**Please note it is the patient's responsibility to be aware of their Insurance Company's requirements for each visit (referrals, copays, vision plans, refractions, etc.). I agree that I am responsible for payments or charges incurred by me or my dependant that are outside the scope of my insurance coverage or for which my insurance company pays me directly. I further agree to be responsible for the office visit if required referrals are not present at the time of visit.*

Reason for Today's Visit? Routine Medical Send Claim to? Primary Vision

If you have an eye problem not related to glasses or contacts, it is considered a medical visit.

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Patient or Guardian Signature: **X** _____

********** DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY **********

Date: _____ R M **Ins**: P V **Changes to Info**? Y N **Pt Init**: _____ **FD**: _____

Date: _____ R M **Ins**: P V **Changes to Info**? Y N **Pt Init**: _____ **FD**: _____

Date: _____ R M **Ins**: P V **Changes to Info**? Y N **Pt Init**: _____ **FD**: _____

Georgia Ophthalmologists

Acknowledgment of Financial Responsibility

Here at the Georgia Ophthalmologist, we want to make sure you have the necessary information to be reimbursed for all covered services. Please understand your insurance only covers services when their rules are met.

- ***Insurance coverage***: It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and authorization requirements as well as vision services. This information is furnished by your insurance carrier. We make copies of you insurance cards assuming the coverage is active at the time of your visit. If your coverage is not in effect at the time of services, you will be responsible for payment.

- ***Insurance Changes***: If you have any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

- ***Co-payments, Co-insurance, and deductibles****:* Co-insurance and co-payments are the patient's/policy holder's responsibility. Co-payments are due at the time of service. Deductibles are the responsibility of the patient/policy holder.

- ***Refractions***: Insurance companies do not pay for refractions unless you are entitled to a routine eye exam or have a separate vision plan. In these instances, refraction fees are due at the time of service.

- ***Referrals*****:** If your plan requires a referral, it is your responsibility to obtain it from your primary doctor prior to your visit. If you wish to be seen without a referral you must sign and comply with our missing referral form.

- ***Insurance Payments***: If by error, an insurance check is sent to you, you should immediately be forwarded to our billing office along with a copy of the explanation of benefits (EOB).

- ***Self Pay Patients***: Self pay patients must pay in full for the examination before any services can be rendered. If after your initial visit further testing is required, pricing will be discussed prior to any procedures.

Name of Patient (PRINT) Signature Date

Signature of Patient Representative Relationship to Patient Date

Georgia Ophthalmologists

PF-2000 Disclosure of Protected Health Information and Consent to Use

Your protected health information will be used by Georgia Ophthalmologist or disclosed to others for the purpose of treatment, obtaining payment or supporting day by day health care operations of the practice.

- *Notice of Privacy Practices*: You should review your Notice of Privacy Practice for a more complete description of how your protected health information may be used or disclosed. Upon request you may review the notice prior to you signing this consent.

- *Requesting a Restriction on the Use or Disclosure of your Information*: You may request a restriction on the use or disclosure of your protected health information. Georgia Ophthalmologists may or may not agree to restrict the use or disclosure of your protected health information. If Georgia Ophthalmologists agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

- *Revocation of Consent*: You may revoke this consent to the use and disclosure of your protected health information. You MUST revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

- *Reservation of the Right to Change Privacy Practice*: Georgia Ophthalmologists reserves the right to modify the privacy practices outlined in this notice.

- *Communication Disclosure Consent:* You are provided the right to request confidential communications or that communications be made via alternative means such as sending information to your place of employment instead of your home. Privacy rules require us to take reasonable steps to limit the use or disclosure of your information to the minimum necessary to accomplish the intended purpose. Uses and disclosures are permitted without prior consent in an emergency.

Name of Patient (PRINT) Signature Date

Signature of Patient Representative Relationship to Patient Date

Georgia Ophthalmologists

Medical History Questionnaire

Patient Name _____ D.O.B _____ Date _____

Please list any medications you are currently taking (include prescribed and over the counter medications)

_____

_____

Do you have any allergies to any medications? … YES NO *If yes, please list:* _____
Do you have any food allergies? ……. YES NO *If yes, please list:* _____
Do you have an allergy to LATEX products? …… YES NO *If yes, please list:* _____

List any surgeries you have had in the past: _____

_____

Please check all that apply:

□ Poor Vision	□ Macular Degeneration	□ Floaters	□ Poor Night Vision
□ Diabetes	□ Tired Eyes	□ Other Eye Surgery	□ Flashes of Light
□ Glaucoma	□ Family History Glaucoma	□ Color Vision Problems	□ Eye Strain
□ Retinal Problems	□ Glare Problems	□ Itching/Burning Eyes	□ Other _____
□ Cataracts	□ Problems Reading	□ Dry Eyes	□ Other _____

Do you currently have any problems in the following areas? If yes, please provide additional information

	YES	NO	DETAILS
General: Fever, weight loss/gain, etc.			
Ear, Nose, & Throat: Hard of Hearing, runny nose, etc.			
Cardiovascular: High BP, racing pulse, etc.			
Respiratory: Congestion, shortness of breath			
Gastrointestinal: Stomach problems, constipation, etc.			
Genitourinary: Painful or frequent urination, impotence, etc.			
Females: Are you pregnant or nursing?			
Musculoskeletal: Joint pain, cramps, arthritis, etc.			
Skin: Pimples, warts, growths, rash, etc.			
Neurological: Numbness or seizures, etc.			
Psychiatric: Anxiety, depression, insomnia, etc.			
Endocrine: Diabetes, thyroid problems, etc.			
Blood/Lymph: Bleeding disorders, anemia, etc.			
Allergic / Immunological: Sneezing, swelling, etc.			
Have you ever had a blood transfusion?			

Family History: Please circle all that apply

Diabetes, Blindness, Cataracts, Glaucoma, High BP, Heart Disease, Stroke, Cancer, Thyroid Disease Arthritis

Social History: Do you drink? YES NO *If yes, how much?* _____
Do you smoke? YES NO *If yes, how much?* _____ *# Yrs?* _____

Physician's Signature _____ Date _____