GEORGIA EYE SPECIALISTS *Welcome to our practice.*

MARIETTA
www.georgiaeye.com

May we ask how you heard about our office?

_____ Friend _____ Doctor _____ Insurance Booklet _____ Drive by
_____ Relative _____ Yellow Pages _____ Employer _____ Emergency
_____ Newspaper Article _____ Internet _____ Mailing

If referred by a friend, relative, or doctor, please complete the following:

Name _____ Address _____ City _____ State _____ Zip _____

PATIENT INFORMATION (Please print) email address _____

Patient's Name _____ Sex M _____ F _____

Date of Birth _____ Age _____ Social Security _____

Marital Status (circle one) Single Married Widowed

Address: Street _____ Apt./Lot # _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell/Work Phone _____

Patient's Employer _____ Occupation _____

Employer's Address _____ City _____

Spouse/Parent/Guardian _____ DOB _____ SS# _____

Spouse/Parent/Guardian Employer _____ Work Phone _____

Family Physician _____ Phone _____

NEAREST RELATIVE / EMERGENCY CONTACT

Name _____

Relationship _____

Address _____

Phone _____

PERSON RESPONSIBLE FOR BILL (if not patient)

Name _____

Address _____

Phone _____ Relationship _____

DOB _____ SS# _____

ATTENTION: **Please be aware that most medical insurances and Medicare do not cover routine eye exams (that is, glasses or contact lens check). If you believe your insurance does cover routine eye exams, please let the front desk know BEFORE you are called to the back so that we may verify your insurance.**

Insurance Authorization and Assignment: I hereby authorize release of medical information to my insurance company and assign to the physician(s) all payments for services rendered to me or my dependents. As is the case with most insurance agreements, the insurance contract is between the patient and the insurance company and not between the insurance and GES. *Payment is expected at the time of the visit, and I understand that I am responsible for any amount not covered by insurance. I understand that testing for glasses and contacts is usually not covered by medical insurance, and I am responsible for this charge. It is my responsibility to obtain a referral should my insurance require it. I must provide a current insurance card.* Thank you for your understanding with these insurance matters.

If your insurance has not paid within 30 days, the balance will become the patient's responsibility.

Date: _____ Signature: _____

PLEASE NOTE: We require payment at time of service. Please indicate how you wish to pay: Cash, Check, CC. There will be a $40.00 fee for all returned checks.

GEORGIA EYE SPECIALISTS
POLICIES

Patient Name _____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **$40.00 return check charge** being added to your account.
2. Please provide us with your current address, telephone number, and insurance information. You may be asked to update this information yearly.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral, it is **your responsibility** to obtain this prior to being seen by the doctor.
5. Your co-pay is due at EVERY visit and will be collected prior to your being brought back to the examination area. There are no exceptions to this policy. Please direct any questions regarding this policy directly to your insurance company. If there are additional charges such as checking glasses, *deductibles*, or other services, these will be collected upon check-out. Please be prepared to pay for these services at the time they are rendered. There is a billing charge of $25 for unpaid deductibles, co-pays or refractions to cover the billing process. We appreciate your help in keeping our costs low by avoiding unnecessary billing charges.

   We realize that co-pays and charges can add up particularly if you are being seen multiple times for the same problem or if a condition is resistant to treatment. However, as a condition of us participating in your insurance, we must collect co-pays for EVERY visit even if it is for a follow-up of an existing problem. If you have questions, please discuss this with your insurance company. Please be aware that for most instances your co-pay (which is for your medical exam) will NOT cover glasses checks, or contact lens fittings or evaluations.
6. Procedures can NOT be done on the same day as your evaluation. If you need to have a procedure done (such as a laser or removal of an eye or eyelid bump), you will have to be scheduled to come in a separate time just for the procedure. This usually results in another visit and another co-pay.
7. Please secure your items including glasses, eye drops, cell phones, computers, and other valuables when you visit our office, and please leave nonessential items in your car trunk. Make sure you have all your items together before you leave a room or testing area. Please be aware that we have a lot of employees and patients walking through our halls so secure your items so they do not fall in case you are bumped. We can not be held liable for any items that are broken, stolen, lost, or dropped. We are often happy to adjust your frames as a favor to you. Glasses often have microcracks and weak spots so please be aware that we can not be held responsible for breakage or damage to your glasses while we are adjusting them for you.
8. The Georgia Eye Specialists are not responsible for lost items including, but not limited to, wallet items, eye drops, purses, glasses, contacts, coats, etc. It is your responsibility to make sure that if you give your items to a staff member that you receive them back immediately.
9. We would greatly appreciate if you could give 24 hour notice if you are unable to keep your appointment. This allows us to offer this time to another patient who needs to be seen. If you do not give 24 hour notice, a charge of $50 will be applied to your account.
10. All medical records requests must be in writing and received in our office 3 weeks prior to the date needed. Records over 10 pages will only be mailed, not faxed, and all medical records requests will have a fee based on the number of pages. There is a charge for forms or letters that you request the doctor or staff fill out or dictate.
11. Glasses or vision exams for the purpose of prescribing, fitting, checking, or changing glasses or contacts are excluded from Medicare and most private insurance coverage. Therefore, examinations for glasses or contact testing are expected to be paid in full at the time of service.
12. In the event the balance on your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You would be responsible for the collection fees incurred.
13. Life is full of changes. Please be prepared to show us your insurance card AT EVERY VISIT so we can be prepared for possible changes in your coverage.
14. If you have questions or concerns about any of these policies, please direct them to the office manager and not the front desk.
15. Charges are nonrefundable.
16. The front office only collects a down payment for your visit. Often, additional testing is required but cannot be anticipated prior to the doctor seeing you. You should be prepared that your final bill is **often** higher than your "down payment" or your estimated charge that you pay on check-in.
17. Please be aware that failure to comply with the treatment plan, including use of medication and follow-up visits, can result in irreversible loss of vision and can even result in serious systemic medical issues. For this reason, it is also important that you report any changes in your eyes to us immediately.

Patient Signature _____ Date _____

Patient Acknowledgement Regarding:

Precautions Following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours or longer. Although we provide free disposable sunglasses or dark sunglass inserts, you may still have difficulty seeing to drive, operate machinery, walk, climb steps, or perform other activities. We recommend that you avoid or be cautious in performing these or other activities after your exam. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely. You should also be aware that if you have any procedures done in the office, including lasers, that your vision may be blurry afterwards.

Dangers of Dilation

There is a very small chance, less than 0.1%, that dilating your eyes can result in elevation in eye pressure (acute glaucoma). If this occurs, it is usually treatable by doing an in office laser procedure. You may refuse to have your eyes dilated, but this will markedly reduce the thoroughness of your exam.

Refraction Service and Fee

*A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses, or if you are planning to have cataract surgery and after completion of cataract and glaucoma surgery. It is also necessary to determine the overall health of the eye even if you do not want glasses.

*A refraction is NOT a covered service by Medicare or most insurance plans, even after surgery. These plans consider a refraction a “vision” service and not a “medical” service.

*Our office fee for a refraction is $65.00, however, if you pay at the time of service we will allow you a prompt pay discount of $20 so your net cost would be $45. This fee is in addition to any copayment, deductible or coinsurance your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Contact Lens Evaluation and Fee

*If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses.

*There is a charge for this service in addition to the refraction fee, and it can vary depending on the type of contact lenses you are currently wearing. Please be aware that your copay (which covers your medical eye exam by the doctor) does NOT cover your contact lens evaluation under most circumstances.

*The doctor will NOT perform a contact lens exam, and you will not receive a contact lens prescription from the doctor. You will see a professional contact lens fitter who can provide this for you. This contact lens fitting may be performed on a separate day depending on the schedule and whether an accurate prescription can be given after your medical exam which comes first.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or a contact lens evaluation, if provided, and understand payment is due at the time of service. I understand that any copayment, coinsurance, or deductibles I may have are separate from and not included in either the refraction fee or contact lens evaluation charge.

Patient’s Name: _____

Patient’s Signature: _____

Date: _____

Fall prevention in the eye doctor's office:

Patients in eye offices are at an increased risk of falls or accidents for a few reasons. Often patients are dilated which can blur vision for driving, walking down steps, or walking outside where it is brighter without allowing time for your eyes to adjust. Additionally, many patients are elderly which places them at a higher risk under all circumstances.

We suggest the following:

1. Have a companion accompany you to drive you home and escort you to your vehicle and to your home or office after an exam. This is particularly important if you are having a procedure such as laser or office minor surgical procedure done or if you are elderly or otherwise unsteady on your feet.

2. Wear sunglasses as you go outside. If you do not have them, we will be happy to provide a pair free of charge.

3. There are a few chairs in our office with wheels. While we try to minimize their use, some are necessary as our equipment is not always mobile. Please be careful when you stand up from a seated position. If you have a history of falls or feel you may be unsteady, please ask for assistance before you stand.

4. Move slowly in our office. Take your time. Allow your eyes and body to adjust.

5. Rest for a moment in our waiting room before you leave to allow your eyes to adjust.

6. You should sit down in the waiting room for at least 30 minutes after any office procedure.

7. Stand still for a moment after you stand to allow yourself to adjust.

8. There are a few throw rugs in the office to keep dirt from coming on the carpets. Please be careful so you do not trip on them.

PLEASE TELL US IF YOU REQUIRE SPECIAL ASSISTANCE OR HAVE HAD A FALL IN THE LAST YEAR.

Patient signature: _____

GEORGIA EYE SPECIALISTS, P.C.

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional. The HIPAA law allows providers to use and disclose protected health information. Your permission is necessary before your health records are shared for any other reason. Georgia Eye Specialists has a duty to protect your health information. You have the right to contact us at info@georgiaeye.com for more information or to make a complaint if you feel your rights are being violated. You also have the right to contact Health and Human Resources.

Patient Information *(please print clearly):*

_____ _____

Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____

Street Address *Apt. #/P.O. Box # (Please include complete mailing address)*

_____ _____

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, Georgia Eye Specialists may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

_____ _____ _____

Business Number *Cell Phone Number* *Other Phone Number*

I authorize the Georgia Eye Specialists to disclose Protected Health Information to the following persons:

☐ Spouse: _____

Name *Phone Number*

☐ Child(ren): _____

Name *Phone Number*

_____

Name *Phone Number*

☐ Other: _____

Name *Phone Number*

Information to be disclosed

☐ All Medical Information ☐ Laboratory Results ☐ All Billing/Account Information

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I understand that I have the right:

To object to the use of my health information for directory purposes.

To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signature/Date:*(date authorization signed by patient or Legal Guardian/Personal Representative)* _____

Month/Day/Year

_____ _____

Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

_____

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

_____

GEORGIA EYE SPECIALISTS

Hersh Chopra, M.D.
Alan L. Benedict, M.D.

PATIENT HISTORY

www.georgiaeye.com

Name: _____ Birth date _____ Today's date _____

IN ORDER FOR US TO PROVIDE YOU WITH THOROUGH MEDICAL CARE, PLEASE DO NOT LEAVE ANY OF THE QUESTIONS BLANK. IF THE QUESTION DOES NOT APPLY TO YOU, PLEASE PUT "N/A". IF YOU DO NOT KNOW - WRITE "I DON'T KNOW".

OPTICAL HISTORY

Are you seeing well through your current glasses? _____
Any problems with reading/computer/driving/T.V. vision? _____
Would you like to get new glasses? _____
Do you like your current frames? _____
Do you want to get new frames? _____
Are you interested in Contact lenses? _____

PAST MEDICAL HISTORY

What medical problems do you have? _____

REVIEW OF SYSTEMS

Do you have any present or past problem in the following areas? If yes, please explain.

Skin Yes / No _____
Eyes Yes / No _____
Ears, nose, throat Yes / No _____
Cardiovascular Yes / No _____
Endocrine (diabetes) Yes / No _____
Who writes your diabetes medication? _____
Pulmonary (lungs) Yes / No _____
Gastrointestinal Yes / No _____
Musculoskeletal Yes / No _____
Neurologic Yes / No _____
Hematologic Yes / No _____
General Yes / No _____
Immune Yes / No _____
Psychiatric Yes / No _____
Other Yes / No _____
Infectious disease (HIV, Hepatitis or other) Yes / No _____

MEDICATIONS (Please list Name/Dosage/Frequency. Please indicate if not oral.) _____

_____

_____

SURGERIES (please list) _____

_____

Do you have any allergies to medicines?: Yes / No If yes, list medications _____

_____

SOCIAL HISTORY

Do you use any tobacco products? Yes / No We recommend that you stop use of tobacco products.
Do you drive? Yes / No
Do you drink alcohol? Yes / No If yes, how much and how often? _____

FAMILY HISTORY

Do you have any health problems in the family? Yes / No If yes, indicate relationship to patient.

cataracts Yes / No _____
glaucoma Yes / No _____
macular degeneration Yes / No _____
diabetes Yes / No _____
other (explain) _____

Are you interested in Lasik?

Yes_____ No_____