



Social Security: _____ Referred by: _____

First MI Last Title

Address Apt# City, State Zip Code

Date of Birth: _____ Age: _____ Marital Status: _____ Male / Female

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Phone #: _____

Permission to contact you via email? Y / N Email: _____

Insurance: Subscriber Self Spouse

Subscriber Name: _____ Date of Birth: _____

Receipt of Notice of Privacy Practices

Initials: _____

I have been notified of Georgia Eye Partners Privacy Policies. I acknowledge I have access to such policies upon request.

Notice of Non-Covered Services

Initials: _____

In an effort to provide you the best quality eye care, it may be necessary to perform a refraction to determine vision potential. This procedure is not covered by Medicare or any other insurance company therefore the patient is responsible for the fee of \$33.00 on the day of service.

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our billing office. Should your account be placed in collections due to non-payment, you will be responsible for the original outstanding charges, as well as any collections fees incurred.

I authorize Georgia Eye Partners to release any information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim / other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Georgia Eye Partners. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for payment for my treatment.

Signature _____ Date _____

PATIENT RIGHTS

Georgia Eye Partners and its staff has adopted the following statement of patient rights and responsibilities. The list includes, but is not limited to, the patient's rights as stated in this policy.

- Patients are treated with respect, consideration and dignity.
- Patients are provided appropriate privacy.
- Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Information is available to patients and staff concerning:
 1. Patient rights, including those specified above
 2. Patient conduct and responsibilities
 3. Services available at the organization
 4. Provisions for after-hours and emergency care
 5. Fees for services
 6. Payment policies
 7. Patient's right to refuse to participate in experimental research
 8. Advance directives, as required by state or federal law and regulation
 9. The credentials of health care professionals

PATIENT COMPLAINT OR GRIEVANCE

Patients have a right to register a complaint against Georgia Eye Partners in writing or by calling Karen Benedikt, Communications Director, without being subjected to discrimination or reprisal. The patient will be free from all forms of abuse and harassment. Georgia Eye Partners will promptly review, investigate and resolve any patient grievances in a timely manner. If the patient feels that they may have an issue, the following contact information is provided.

Georgia Eye Partners
Attn: Karen Benedikt
550 Peachtree St., NE; Suite 1500
Atlanta, GA 30308

Composite State Board of Medical Examiners
2 Peachtree Street, N.W. 10th Floor
Atlanta, GA 30303-3465
404-656-3913
<http://medicalboard.georgia.gov>

Healthcare Facility Regulation Division
Georgia Department of Community Health
2 Peachtree Street, Suite 31-447
Atlanta, GA 30303-3142
404-657-6487
<http://ors.dhr.georgia.gov/portal/site/DHR-ORS/>

The law requires the Board to respond in writing to all complaints within 60 days

All Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage at:
www.cms.hhs.gov/center/ombudsman.asp

PATIENT RESPONSIBILITIES

Prior to receiving care, patients are informed of patient responsibilities. These responsibilities require the patient to:

- Provide complete and accurate information to the best of his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider.
- Inform the patient's provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance on the date of service, including co-payment, co-insurance and/or deductible.
- Bring your insurance information to each visit.
- Accepts personal financial responsibility for medical care not covered by insurance.
- Be respectful of all health care providers and staff, as well as other patients.
- Patients are informed of their right to change their provider if other qualified providers are available.
- Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
- Patients are informed about procedures for expressing suggestions, complaints and grievance, including those required by state and federal regulations.
- Patients are entitled to prompt return of any money incorrectly collected.

PRIVACY AND CONFIDENTIALITY

Georgia Eye Partners complies with federal HIPAA (Health Insurance Portability and Accountability Act) regulations to maintain privacy of the patient's health information.

ADVANCED DIRECTIVE

Georgia Eye Partners is not an acute care facility; therefore regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney, if any adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Your agreement with this policy does not revoke or invalidate any current health care directives or health care power of attorney.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE I HAVE READ, UNDERSTAND AND AGREE TO ITS CONTENTS.

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE

DATE: ____/____/____



History Form

Name: _____ Referring Doctor: _____

Reason for visit today: _____

Occupation: _____ Retired: Yes / No

Smoker: Yes / No (_____ packs per day) Alcohol drinker: Yes / No (_____ per day)

Patient:

- Y / N Cataract
- Y / N Glaucoma
- Y / N Trauma / Injury
- Y / N Cornea problem
- Y / N Retinal Tear / Detachment
- Y / N Macular Degeneration
- Y / N Diabetic Eye Disease

Family History:

- Y / N Cataract
- Y / N Glaucoma
- Y / N Cornea problem
- Y / N Macular Degeneration
- Y / N Retinal Tear / Detachment

Other: _____

Have you ever been treated for the following? If so, please describe.

- Y / N Diabetes _____ years Diet controlled / Insulin Dependent
- Y / N High Blood Pressure _____ years
- Y / N Heart attach / Heart disease
- Y / N Kidney disease / kidney stone / Liver disease / Hepatitis
- Y / N Lung Disease
- Y / N Neurological: Stroke
- Y / N Cancer
- Y / N AIDS / HIV
- Y / N Abnormal bleeding
- Y / N Arthritis
- Y / N Gastrointestinal problems
- Y / N Are you pregnant now or is there a possibility you may be?

General Surgery? If so, what type and date performed?

List all current medications, strengths and dosage: _____

