Welcome to our Practice

We would like to thank you for putting your trust in Georgia Eye Partners and our team. Our goal is to provide you with excellent vision care. This packet is to ensure your understanding of our practice and policies.

We are excited to meet you the day of your appointment. Your initial exam will normally last approximately 2 hours. More complex exams or testing will take longer, and we ask you to plan the day of your appointment accordingly. Dilation of your pupils usually wears off within 2-3 hours and may make driving more difficult. If you have never experienced the effects of dilation, we recommend arranging for someone to drive you home from your appointment.

An explanation of our financial policy is included in this packet. If you have any further questions, please feel free to contact our Patient Accounts Department at (404) 953-4000.

HOW TO PREPARE FOR YOUR APPOINTMENT:

1. You will need to complete your registration online by visiting our website at www.GaEyePartners.com and clicking "Online Patient Registration". When you press 'submit', you will be given a confirmation number. Please make note of this number.
2. While on our website, we encourage you to explore the site where you will find directions to our offices, frequently asked questions and videos on procedures we provide.

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:

1. Online registration confirmation number
2. Current insurance cards and photo I.D.
3. List of all current medications and pharmacy information
4. Referral – It is your responsibility to determine if one is required by your insurance and to have the referral with you at the time of your visit.
5. Your current glasses and/or contact lenses

Once again, thank you for entrusting your vision to Georgia Eye Partners.

Northside
1100 Johnson Ferry Rd., NE
Bldg 1, Suites 105, 108, 140
Atlanta, GA 30342
P: (404) 531-9988
F: (404) 531-9488

Midtown
550 Peachtree St., NE
Suite 1500
Atlanta, GA 30308
P: (404) 897-6810
F: (404) 897-4924

Johns Creek
10080 Medlock Bridge Rd.
Johns Creek, GA 30097

P: (770) 623-3931
F: (770) 623-3937

Woodstock
900 Towne Lake Pkwy.
Suite 312
Woodstock, GA 30189
P: (404) 953-4044
F: (404) 953-4055

GEORGIA EYE PARTNERS

PATIENT REGISTRATION FORM

_____ ___ _____ Mr/Mrs/Ms/Miss/Dr/Rev
First Name MI Last Name

Social Security #: _____ How did you hear about us? _____

_____
Address (Apt#) City, State Zip Code

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

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

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

Permission to contact you via text message? Y / N Primary Language: _____ Race: _____

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Decline to Provide

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

****Please complete the following information if patient is a minor****

Father's Name: _____ Work #: _____ Cell #: _____

Mother's Name: _____ Work #: _____ Cell #: _____

Father's Occupation: _____ Mother's Occupation: _____

Medical Insurance Information

Insurance Company: _____ Subscriber's Name: _____

Subscriber's SSN: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Relationship to Subscriber: _____

Signature _____ Date_____

GEORGIA EYE PARTNERS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) AND OBTAIN AND USE PRESCRIPTION HISTORY

1. With your permission, we may disclose your PHI to the individuals identified below. I authorize Georgia Eye Partners to release any personal information relating to my health care

   To: _____ Relationship to Patient: _____

   To: _____ Relationship to Patient: _____

2. I understand that I have the right to restrict information that may be released, and that this restriction must be in writing. (Please initial below)

   _____ No restrictions

   _____ With restrictions (list): _____

3. I agree that Georgia Eye Partners may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

4. I have received a copy of the Notice of Privacy Practices for Georgia Eye Partners, and I acknowledge that I am familiar with and understand the terms and conditions.

Name (printed) _____

_____ _____

Signature Date

AUTHORITY FOR TREATMENT

IF PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION

No child under the age of 16 (sixteen) may be left unattended!

I hereby authorize the providers at Georgia Eye Partners to examine, diagnose and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name: _____ Patient's Date of Birth: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (printed) : _____ Date: _____

Relationship to Patient: _____

If parents are divorced, who is the custodial parent? ☐ Mother ☐ Father ☐ Both (Joint Custody)

Has a legal guardian been appointed? ☐ Yes ☐ No If yes, specify name _____

GEORGIA EYE PARTNERS

Patient and Family History Form

Date:_____

Name: _____ Referring Doctor: _____

Reason for today's visit: _____

Occupation: _____ Retired: Yes / No

Tobacco use, any form: Y / N _____ packs per day Other type of tobacco:_____ Quit date: _____
Alcohol use: Y / N _____ drinks per day / week / month / year Quit date:_____

Allergies to medications: Y / N (Please list)_____

Patient History:

Y / N Cataract
Y / N Glaucoma
Y / N Injury
Y / N Cornea Problem
Y / N Macular Degeneration
Y / N Retinal Tear / Detachment
Y / N Diabetic Eye Disease

Family History (relative):

Y / N Cataract _____
Y / N Glaucoma _____
Y / N Cornea Problem _____
Y / N Macular Degeneration _____
Y / N Retinal Tear / Detachment _____
Y / N Diabetes _____

Are you being treated or have you ever been treated for the following? If so, please describe.

Y / N Diabetes: _____ years Circle one: Diet controlled Oral Medication Insulin Dependent
Y / N High Blood Pressure: _____ years
Y / N Heart attack / Heart disease: _____
Y / N Kidney disease / Kidney stone / Liver disease / Hepatitis (Circle): _____
Y / N Lung Disease: _____
Y / N Neurologic Disease (such as stroke): _____
Y / N Cancer: _____
Y / N AIDS / HIV: Diagnosed in _____
Y / N Abnormal bleeding: _____
Y / N Arthritis: _____Rheumatoid? Y / N Other_____
Y / N Gastrointestinal problems: _____
Y / N Are you pregnant or is there a possibility you might be?

Other: _____

Eye Surgeries, Injuries, Diseases (Please list with dates, doctor): _____
_____
_____

Eye Medications (Include dosage and frequency): _____
_____
_____

Other Surgeries: No / Yes (List with dates): _____
_____
_____

Other Medications : No / Yes (Include dosage and frequency): _____
_____
_____

List additional medications and surgeries on the back of this page.

Patient Acknowledgement Regarding Financial Responsibility

In order for us to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the patient's obligations and how to meet them. In exchange for services rendered, each patient or patient's guarantor agrees:

- To authorize payment of surgical and medical benefits to us, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVII, and or XIX of the Social Security Act is correct.
- To pay for all non-covered charges, co-pays, co-insurance, deductible, out-of-network charges, and refractions (the measurement of the eye in order to obtain a prescription for glasses or contacts) at the time of service or when otherwise advised. If this is not possible, you agree to contact our Billing Office at (404) 953-4000 BEFORE services are rendered. If we have to send you a statement for your copay or you fail to notify us of an appointment cancellation at least 24 hours in advance, you will incur a processing fee.
    - Refraction Fee: $33.00
    - Contact Lens Fitting Fee: This fee varies depending on the type of contact lens you request or the type of contact necessary to provide you the best possible vision. If you are new to contact lenses or desire to change brands, there is a fee for the fitting. The fee is collected in addition to the fee for an eye examination.
- To provide us with a copy of your most recent insurance card or other proof of insurance and/or register with the receptionist at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit, and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.
- To obtain any authorization or referral required by your insurance plan and/or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization, your insurance company may not pay us for our services. In this case, you are personally responsible for any and all charges. Additionally, we may need to reschedule your visit if you do not have your authorization or referral.
- To monitor your insurance company's payment of your account and if unpaid 30 days after the date of service, to contact them regarding their non-payment. You also agree to cooperate with us in resolving the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine eye care, we will provide a reduced charge for payment made at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, we will not be responsible for filing claims to any insurance company nor will we accept payment on a discounted rate from the insurance company. In the event we receive a payment from an insurance company under this circumstance, we will refund the money to the insurance company.

As the patient or guarantor of a patient, I agree that in consideration of the services rendered by us, that I am individually obligated to pay for all services in accordance with the regular rates, terms and conditions of Georgia Eye Partners. In the event we must refer the patient's account to a collection agency or attorney for collection of an amount 90 days or older, the patient and/or guarantor agrees to pay our collection fee, including any accrued interest and all applicable bank fees incurred for a returned check.

I voluntarily consent to healthcare treatment from the physicians and staff at Georgia Eye Partners. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding the results of treatment or examinations by my provider. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

_____ _____

Patient or Guarantor - Signature Date