Welcome to our Practice

First, let us thank you for putting your trust in Georgia Eye Partners and our team. Our goal in providing this packet of information is to make the process as easy as possible as well as ensure all your questions are answered. We truly consider our staff a family and our goal is to provide each patient with the same high level of care that we would provide to our own family members.

We are excited to meet you at your appointment. The initial first full length exam will normally last a little **over two hours**. We use the latest and most current diagnostic equipment available today. During your exam you may have up to as many as six quick non-invasive tests done to ensure you get the highest level of care possible. All of this is part of a complete medical eye exam, which is a little lengthier than your normal annual exam. Your eyes will most likely be dilated at the exam, which can result in blurred vision and increased glare lasting a few hours. It is best for you to arrange for transportation so you don't have to worry about driving. We recommend inviting a spouse, family member, or friend to the exam.

Enclosed in Packet

- Patient Registration Form
- PHI Authorization Form
- Medical History Questionnaire
- Patient Financial Responsibility Form

Please complete these forms prior to your office visit. Completing this information prior to your visit will allow more time to focus on your individual needs and discuss which option is best for you and your lifestyle. Please be sure to bring these completed forms with you to your appointment. You should also bring your most current glasses and/or contact lenses with you for your eye exam. Please be sure to bring all your insurance information, insurance cards, and photo identification with you to your appointment. The Notice of Privacy is for your records.

At your appointment our doctors and staff will take the time to explain all your options and together you will make a decision which works best for you and your lifestyle. If you would like to educate yourself prior to your exam we hope you will visit our website at www.gaeyepartners.com. Directions to our offices, frequently asked questions and animated videos on some of the procedures we provide are also available on the website.

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

Northside
1100 Johnson Ferry Rd, NE
Building 1, Suite 140
Atlanta, GA 30342
P: (404)897-6810
F: (404)897-4924

Midtown
550 Peachtree Street, NE
Suite 1500
Atlanta, GA 30308
P: (404)531-9988
F: (404)531-9498

PATIENT REGISTRATION FORM

Social Security: ___________________ How did you hear about us? _________________________________

_______________________________ ___ ____________________________ Mr/Mrs/Ms/Miss/Dr/Rev
First MI Last

____
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

Emergency Contact Information

Name: ______________________________ Relationship: ______________ Phone: __________________

Name: ______________________________ Relationship: ______________ Phone: _________________

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

Father's Name: ________________________ Work Phone: ______________ Cell Phone: _____________

Mother's Name: ________________________ Work Phone: _____________ Cell Phone: _____________

Father's Occupation: ___________________________ Mother's Occupation: _________________________

Medical Insurance Information

Insurance Co. Name : ________________________ Subscriber Name: _______________________________

Subscriber SSN: _____________________________________ Subscriber Date of Birth: ________________

Subscriber's Employer: ________________________________ Relationship to subscriber: ____________

Signature ____ Date____________________________________

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 release and that this restriction must be in writing.

   ______________ 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 their 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 _______________________________________ Date____________________________________

____
Signature

AUTHORITY OFR 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: ___________________________________ 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 ____________________

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: ______________________

____

____

Patient Financial Responsibility Agreement

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 obligations we require from our patients and how our patients meet these obligations. In exchange for services rendered, each patient 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.
- 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 these cases, 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 following 30 days from the date of service to contact them regarding their non-payment. You also agree to cooperate with us to resolve 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 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 to file 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 back to the insurance company.

The patient or guarantor of a patient agrees that in consideration of the services rendered by us, that you are 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. Additionally, the undersigned agrees that there will be a 20% finance charge on all unpaid balances over 60 days old.

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 caregivers. 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 red, understand and agree to be bound by the above provisions.

______________________________ ______________________

Patient or Guarantor - Signature Date