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.

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__________________________ ___ ____________________ 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: _______ Sex: M/F Height _____ Weight _____

Home #: _________________ Work #: _________________ Cell #: ________________

Email: ______________________________ Primary Language: _________

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

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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____________________________

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Patient Acknowledgement
Receipt of Privacy Notice

I, ________________________________ hereby affirm that a copy of the *Notice of Privacy Practices* from **Georgia Eye Partners** has been presented to me and a copy is available upon request. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have been presented with a copy of the *Notice* and a copy is available upon request, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

________________________________ ____________________________
Signature of Patient or Legal Guardian Date

____
Name of Patient or Legal Guardian

Appointment Cancellation Policy

Our goal is to provide quality medical care in a timely manner to all patients and time has been specifically reserved for your appointment.

Effective **April 2, 2018**, we will require a notification of cancellation 24 hours prior to your appointment. Failure to provide a 24 hour cancellation notice may result in a charge of **$40.00**.
We greatly appreciate your understanding and continually strive to make your experience the best possible.

________________________________ ____________________________
Signature of Patient or Legal Guardian Date

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Designated Party Release & Communication Consent

You may give **Georgia Eye Partners** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below.

At my request, I authorize **Georgia Eye Partners** to disclose my protected health information to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

You may also use this form to give **Georgia Eye Partners** consent to leave detailed information and communicate medical history more efficiently (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

At my request, I also authorize **Georgia Eye Partners** to communicate my protected health information to me via the following methods:

☐Leave detailed message on my home answering machine. Phone number: (___) _____-_______

☐Leave detailed message on my voice mail at work. Phone number: (___) _____-_______

☐Leave detailed message on my cell phone voice mail. Phone number: (___) _____-_______

☐Fax detailed medical information. FAX number: (___) _____-_______

☐E-mail detailed medical information. Email address____

☐I agree to receive text messages to this mobile phone number (___) _____-_______ reminding me about my upcoming appointments. I understand that SMS reminders are optional and that message & data rates may apply.

☐ *I do not give **Georgia Eye Partners** permission to leave detailed messages on my voicemail, email or fax machine and I understand that any medical communication will be delayed until Georgia Eye Partners is able to reach me.*

I understand that I may cancel this authorization at any time. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Georgia Eye Partners** took in reliance on this authorization before receipt of written notice of cancellation.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of **Georgia Eye Partners**. I agree to assume such risks personally, and to hold **Georgia Eye Partners** harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing **Georgia Eye Partners** to transmit or deliver such information electronically.

Patient's Name	**Date of Birth**
Patient or legal Guardian's Signature	**Date**

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Patient Health History

Patient Name:____ Today's Date:______________________
Occupation:____ Referring Doctor:___________________
Reason for today's visit____

Most recent eye doctor:__________________________ Primary care physician:__________________________
Date of last eye exam:___________________________ Date of last medical exam: _______________________

Y / N Do you wear glasses/contacts/both? *(circle)* If wearing contacts, are they soft/hard? *(circle)*

Have you received a flu shot recently? ☐ Yes ☐ No If yes, when? ________________________

Have you received the pneumonia vaccination recently? ☐ Yes ☐ No If yes, when? ___________________

Do you have or have previously been treated for (If so, please describe):

Y / N Cataract_________________________________
Y / N Glaucoma________________________________
Y / N Macular Degeneration______________________
Y / N Eye Injury________________________________
Y / N Dry Eyes_________________________________
Y / N Cornea Disease___________________________
Y / N Retinal Tear/Detachment___________________
Y / N Diabetic Eye Disease______________________
Y / N Crossed Eyes/Lazy Eye____________________
Y / N Other____________________________________

Y / N Diabetes: _______ years
Controlled by: Diet/Pills/Insulin *(circle)*
Y / N High Blood Pressure: _______ years
Y / N Heart Attack/Heart Disease_________________
Y / N Kidney Disease____________________________
Y / N Liver Disease_____________________________
Y / N Stroke___________________________________
Y / N Cancer___________________________________
Y / N HIV/AIDS_________________________________
Y / N Abnormal Bleeding_________________________
Y / N Arthritis_________________________________
Y / N Gastrointestinal Problems__________________
Y / N Are you pregnant/breastfeeding? Due date_____
Y / N Other____________________________________

Y / N Eye Surgeries (please list with dates, doctor)

____
____

Y / N Other Surgeries (please list with dates, doctor)

____
____

Y / N Eye Medications (prescription and over the counter, include dosage and frequency)

____
____
____

Y / N Other Medications (prescription and over the counter, include dosage and frequency)

____
____
____

Y / N Are you allergic to any medications? If yes, please list:____

Patient Name: ____ **Date:** _______________

Has anyone in your family had any of the following? If yes, please list relationship.

Y / N Cataract____________________________
Y / N Glaucoma___________________________
Y / N Macular Degeneration_______________________
Y / N Corneal Disease___________________________
Y / N Retinal Tear/Detachment___________________
Y / N Crossed Eyes/Lazy Eye____________________
Y / N Diabetes___________________________________
Y / N Other______________________________________

Patient Health History

Social History

Y / N Never Smoker
Y / N Former Smoker: Quit date______
Y / N Current Smoker: _____ packs/day

Y / N Alcohol Use
If yes: Y / N 3 or less drinks per week
Y / N 4 or more drinks per week

Review of Systems

Are you currently experiencing any problems:	Yes	No	Details
Constitution *(Weight gain, loss of appetite, other)*			
Cardiovascular *(Chest pain, irregular rhythm, other)*			
Ear, Nose, Mouth, Throat *(Dry mouth, sore throat, runny nose, earache, other)*			
Respiratory *(Shortness of breath, wheezing, cough, other)*			
Gastrointestinal *(Constipation, diarrhea, acid reflux, other)*			
Genitourinary *(Painful urination, incontinence, other)*			
Musculoskeletal *(Joint pain, muscle ache, joint swelling, other)*			
Integumentary *(Skin rash, itching, other)*			
Neurological *(Headache, dizziness, other)*			
Psychiatric *(Anxiety, depression, other)*			
Endocrine *(Frequent urination, frequent thirst, always hot or cold, other)*			
Hematologic/Lymphatic *(Anemia, excessive bleeding, other)*			
Allergic/Immunologic *(Hay fever, itchy eyes, other)*			

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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: This fee is $40.00.
    - 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. 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

Rev.033018kpb