SOUTH GEORGIA EYE PARTNERS, PC

PATIENT INFORMATION

Legal First Name ______ Middle ______ Last ______

Address ______ City ______ State ______ Zip ______

Home Phone ______ (Circle) Male / Female   Single / Married / Widowed / Separated / Divorced

Date of Birth: ______ Age ______ SS#: ______

Patient Employed By: ______ Wk. Phone: ______

Are you Retired? Yes / No   Date Retired: ______ (Month/Year)   E-Mail Address: ______

Cell Phone: ______ How did you learn about our office? ______

Name of Doctor who referred you: ______ City: ______ Phone #: ______

Whom to notify in case of emergency? ______ Home Phone: ______ Wk. Phone: ______

SPOUSE INFORMATION

Name: ______ Employer: ______

Date of Birth: ______ Work Phone: ______

SS #: ______ Retired? Yes / No   Date Retired: ______

MUST COMPLETE IF UNDER 18 OR USING GUARDIANS INSURANCE

Father	Mother
Name: ______	Name: ______
Date of Birth: ______	Date of Birth: ______
SS #: ______	SS #: ______
Employer: ______	Employer: ______
Work Phone: ______	Work Phone: ______

AUTHORIZATIONS

**************PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST*************

* I hereby authorize and request the medical treatment necessary for the care of the above patient.
* I authorize SOUTH GEORGIA EYE PARTNERS, PC to use and disclose protected health information about above name patient to carry out treatment, payment and healthcare operations. I understand that this may include the release of all medical records to the referring and family physicians and to my insurance company. If applicable. I allow the fax transmittal of my medical records if necessary.
* I acknowledge full financial responsibility for services rendered by South Georgia Eye Partners, PC. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
* I further authorize and request that insurance payments be made directly to South Georgia Eye Partners, PC should they elect to receive such.
* I acknowledge that I have received a copy of our Notice of Privacy practices. A copy is located in the lobby of the office.
* I understand my email address may be used solely to relay information regarding appointments, non-critical test results, or other general information.
* I certify that the information I have provided is true and accurate and that I understand and agree to all the patient responsibilities outlined above.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

______ Date   ______ Patient / Parent or Guardian Signature

The Optomap Retinal Exam is used by your eye doctor to get an ultra-wide field view of the retina (the back of the eye). While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough screening of the retina is critical to verify that your eye is healthy. This can lead to early detection of common diseases, such as glaucoma, diabetes, macular degeneration, and even cancer.

Your doctor highly recommends that you have an Optomap® Retinal Exam as part of your yearly exam, it is a comprehensive method of evaluating, monitoring, and helping treat various eye conditions. This previously unavailable medical technology assists your doctor in viewing the entire retina and provides a permanent record of the appearance of your eye to enhance our ability to care for your eye in the future, as well.

The exam is quick, painless, and may not require dilation drops. Results will be personally reviewed with you by your doctor.

This part of your exam is $39 and NOT covered by your insurance.

______ I understand that a wide field view of the retina is an important part of a comprehensive eye exam and accept my doctor's recommendation to have the Optomap retinal exam even though my insurance will not pay for the exam.

______ I would like more information from the technician/doctor before I decide.

______ I understand the information provided above, but choose to decline this testing against the recommendation of my doctor.

Patient's signature______________________________ Date: ______________

Authorization for Use and Disclosure of Protected Health Information

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I ______________________________ am authorizing South Georgia Eye Partners to release medical information to:

Name	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

This authorization is valid as of _____/_____/_______, the date I signed below. This remains in effect until I give notification to discontinue.

____
Name of Individual (Printed)

____
Signature of Individual

____
Signature of Legal Representative
(guardian, parent (if patient is a minor)

____
Relationship

Date Signed: _____/_____/_________

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your eye care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours.** We understand that circumstances arise that do not allow you to keep your appointment, but please remember to be courteous to us and our patients by calling **24 hours** prior to your appointment time to cancel if you cannot make it. The first time there is a **"missed"** appointment there will be no charge to the patient. Any additional **"missed"** appointments will result in a **fee of $25.00** billed to the patient's account. This charge is not covered by your insurance.

REFRACTION FEE

Refraction is the process of determining the prescription for your glasses. Refraction is also an important tool that aids in the diagnosis and treatment of many eye conditions. Refraction does not include any screening or examination. Federal guidelines require that refraction must be billed separately for all patients. **Medicare *does not* cover refraction.** Because Medicare considers this a non-covered service, your supplemental insurance will also deny payment. While some insurance plans may recognize and pay for refractions, most do not. Refraction is performed on almost all complete eye exams and payment will be expected at time of service unless coverage and eligibility is verified. The refraction fee is $35.00.

CONTACT LENSE FITTING FEES

Contact lens fitting fees include determining if contact lenses can be safely fit and which lenses give the best vision, comfort and health. This includes measurements of the eye, design and selection of lenses, fitting of lenses on the eye, instruction on insertion, removal of lenses and care of the lenses, and follow-up visits **for up to eight weeks**. Once you have been wearing contact lenses your doctor will require examination at least once a year to verify that your contact lens prescription is still appropriate and healthy for your eyes. Most of the time Medical insurance does not pay for these services; some vision plans do provide some coverage for contact lens services. It is best to check with your insurance carrier to find out what coverage you have for contact lens services. Our fitting fees range from $60.00 to $175.00 depending on the patient's specific needs/complicity. Renewal and refitting fees range from $30.00 to $100.00. Contact lens fitting fees are due at time of service and no contact lenses will be dispensed prior to these fees being paid.

I have read and understand the policies stated above:

PRINT PATIENT NAME: ____

PATIENT OR GUARANTOR SIGNATURE: ________________________________

DATE: ________________________

Name:______________________ DOB:______________ Date:______________ Pt.#______________

Yes	No	
☐	☐	Breathing problems / Asthma /COPD/ Emphysema
☐	☐	Cancer(s)
☐	☐	Kidney problems / stones
☐	☐	Rheumatoid Arthritis
☐	☐	Heart disease / Angina / Heart Attacks
☐	☐	High blood pressure / Strokes
☐	☐	Thyroid problems / Diabetes
☐	☐	Skin Problems / Rosecea
☐	☐	Liver / Gall bladder disease
☐	☐	Sinus problems / Allergies
☐	☐	Headaches / Migraines / Seizures
☐	☐	Anemia / Bleeding disorders / sickle cell
☐	☐	Blood clots / Elevated Cholesterol
☐	☐	Tuberculosis
☐	☐	Immune system problems / HIV
☐	☐	Permanent defect from Illness / Injury
☐	☐	Do you feel well today?
☐	☐	Other ______________________

Past Systemic Procedures/Surgeries

____

____

____

____

Family History

Yes	No	
☐	☐	Cataract ______________________
☐	☐	Glaucoma ______________________
☐	☐	Arthritis ______________________
☐	☐	Diabetes ______________________
☐	☐	High Blood Pressure ______________
☐	☐	Bleeding Disorders ______________
☐	☐	Macular Degeneration ____________
☐	☐	Stroke ______________________
☐	☐	Heart Disease ______________________

Social History

Do you / have you used tobacco products? Yes ☐ No ☐

#PPD ____________ Years _____ Smokeless _______

Do you drink alcohol? Yes ☐ No ☐

Drinks/month ______________________

Ocular Procedures/Surgeries

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Current Ocular Dx ______________

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Can we give your medical information to other members of your family or friends? Yes ☐ No ☐

If yes, please list names and their relationship to you.

____

____

____

Allergies to medications: ☐ **no known drug allergies** ☐ **latex allergies**

______________ ______________ ______________________

Current Systemic meds? (name. dose, frequency)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Current Eye meds? (name. dose, frequency)

______________ ______________ ______________

______________ ______________ ______________