SOUTH GEORGIA
NORTH FLORIDA
eye partners

PATIENT INFORMATION

_____
First Middle Last, Suffix

Address: _____

_____ _____ _____
City State Zip

SSN: _____ Circle: Single/Married/Other

DOB: _____ Circle: Male/Female

Emergency Contact: _____
First Last

Relationship: _____

Phone: _____

☐ Mobile ☐ Home ☐ Work

Race: ☐ Asian ☐ African American ☐ Hispanic/Latino
☐ Caucasian ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ ASL
☐ Other: _____

Check the boxes if you want to be contacted through these means.

☐ Mobile Phone: _____

☐ Home Phone: _____

☐ Email: _____

Preferred Contact: _____

Circle: Employed | Student

Occupation: _____

Company or School: _____

Address: _____

_____ _____ _____
City State Zip

Primary Care Physician: _____

Referral Source: _____

Referred by Patient: ☐ Yes ☐ No

POLICY HOLDER INFORMATION

_____
Prefix Title Suffix

_____
First Middle Last

Address: _____

_____

_____ _____ _____
City State Zip

Employer/School: _____

DOB: _____

SSN: _____

Phone: _____

Patient Relationship to the Policy Holder:

_____

Gender of Insured Party: ☐ Male ☐ Female

Responsible Party: ☐ Patient ☐ Policy Holder ☐ Other

INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No

Do you have vision insurance? ☐ Yes ☐ No

Insurance: _____ Effective Date: _____

Policy No.: _____

Insurance: _____ Effective Date: _____

Policy No.: _____

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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 | NORTH FLORIDA EYE PARTNERS, PC 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.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Relationship
(if patient is a minor)

**If patient is a minor and could have grandparents, etc. present with minor for appointment, please list them here.

POLICY AND FEES AGREEMENT

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your eye care provider. To give you and all our patients the best possible care, we request that you review our policy regarding missed appointments. We understand that circumstances occasionally arise that do not allow you to keep your appointment but **failing to arrive to your allotted appointment time without sending a cancellation notice AT LEAST 24 HOURS IN ADVANCE will cause a missed appointment to go on your record.** All missed appointments result in a **fee of $50.00** billed directly to your patient account. This charge is not covered by your insurance.

REFRACTION FEE

The refraction process determines the prescription for your lenses and aids in the diagnosis and treatment of many eye diseases. 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.** Since Medicare considers this a non-covered service, your supplemental insurance will deny payment as well. 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 the time of service unless coverage and eligibility are verified. **The refraction fee is $40.00.**

CONTACT LENS FITTING FEES

A contact lens fitting determines if the contact lenses safely fit on your eyes and which lenses provide the best vision, comfort, and health for your eyes. The process includes the measurement of the eyes; the design and selection of lenses; and follow-up visits **up to eight weeks**. After wearing contacts for a period, your doctor will require a reexamination 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 insurances do not pay for these services though some vision plans do provide partial coverage for contact lens services. Check with your insurance carrier to verify what coverage you have for contact lens services. Our fitting fees for disposable contact lenses range from $75.00 to $325.00, depending on specific needs/complicity. Refitting fees for disposable contact lenses range from $55.00 to $250.00. Contact lens fitting fees are due at the time of service. No contact lenses will be dispensed prior to the payment of these fees.

The signature below confirms that I have read and fully understand the policies listed above.

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 | NORTH FLORDIA EYE PARTNERS, PC to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.
- I acknowledge full financial responsibility for services rendered at SOUTH GEORGIA / NORTH FLORDIA 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 a default of payment of my charges.

- I further authorize and request that insurance payments be made directly to SOUTH GEORGIA / NORTH FLORDIA EYE PARTNERS, PC if they elect such an arrangement.
- I acknowledge that there will be a $1.00 hold placed on my debit/credit card prior to processing to verify credit ability. This $1.00 will be refunded within 48 hours.
- I acknowledge that Optomap Retinal Imaging is NOT covered by insurance as part of the regular eye exam. Should I elect to receive the Retinal Imaging, I acknowledge full financial responsibility and I understand payment is due at the time of service.
- I acknowledge that I have received a copy of the Notice of Privacy Practices. A copy is in the lobby of the office.
- I acknowledge my email 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 I understand and agree to all the patient responsibilities previously outlined.

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

_____

Patient Name

_____ _____

Patient / Parent or Guardian Signature Date