Welcome to Eye Physicians & Surgeons, PC,
Atlanta LASIK Center and Atlanta Eyewear

If you are a new patient to our practice and would like to complete new patient forms before you arrive, please print and complete the forms attached.

- **Patient Information Form**
- **Patient Notice of Privacy & Pharmacy Information Form**
- **Medical History Questionnaire**
- **List of Medications (if applicable)**
- **Financial Policy**
- **Medical vs. Vision (information only)**
- **Authorization for Release of Records to EPS** (*you only need to complete this form if prior medical records are needed from another physician's office.)*

Please bring the completed forms to your first visit.

In addition to the above forms, you should bring the following items:

- **Insurance cards** (We will make a copy of your insurance cards, front and back.)
- **Driver's License** (We will make a copy of your driver's license.)
- **All glasses that you are currently wearing or last glasses worn**
- If applicable**, a referral from your primary care physician**. (We do not obtain referrals on the day of your visit; referrals should be done prior to the visit.)

If you have any questions, please call our office at (404) 292-2500 or email us at info@atlantaeye.com.

We look forward to meeting you.

EYE PHYSICIANS and SURGEONS, P.C.

PATIENT INFORMATION

LEGAL NAME: ______________________ , ________________________ ________________________

Last Name First Name Middle Initial

Street Address ____ Apt. # ____________________

City ________________________________ State ________________________ Zip _______________

Phone:____________________________________ Alternate Phone:____________________________

SS#:_________________________ Date of Birth: _______________________ Sex: M or F

Marital Status _______________ E-MAIL ADDRESS ____

Responsible Party (If patient is a minor, parent or guardian should complete this section.)

Responsible Party: ______________________ , ____________________ _________________________

Last Name First Name Middle Initial

Relationship to patient:_________________________ Home Phone Number: ______________________

E-MAIL ADDRESS _______________________________________SS#:___________________________

Date of Birth:________________

Street Address ____ Apt. # ____________________

City____________________________State_________________________Zip_______________________

Employer Name: __________________________________ Work Phone:_______________ ext. ________

Employer Address: ____

Street Address City State Zip

METHOD OF PAYMENT ______Cash ______Check ______Credit Card ______ Ins.

How did you hear about our practice? ____

Please indicate the persons name, internet site, advertisement, doctor's office, etc. that referred you to us.

Referring/Primary Care Physician:

Dr. _______________________ ___________________________________ ___________________

First Name Last Name Phone Number

Name of Insurance Company

Primary Insurance Company Name:

____

Secondary Ins. Co. Name

____

*Only need name of insurance, we will make a copy of your insurance card with the detail information

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to the Physician for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature of Patient (or parent/guardian if a minor) ______________________________ Date ______________

Meaningful Use Patient Registration Form:

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process.
Please complete the information below.

Patient Full Name: ____
First Name Middle Name Last Name Suffix (Jr. St, II)

Date of Birth: ___________________________ **Age:** _______________

Email address: ____@____________________________
Please print legibly

Preferred Method of Communication:

(provide number)
___Home phone ________________________
___Mobile phone ________________________
___Work phone ________________________
___Other phone ________________________

___Email
___Secure Email
___U.S. Mail

Ethnicity:
___Hispanic
___Non-Hispanic
___Unknown
___Decline to answer

Race:
___American Indian/Alaska Native
___Asian
___Black/African American
___Native Hawaiian/ Other Pacific Islander
___White/Caucasian
___Decline to answer

Primary/Preferred Language:
___English
___Spanish
___French
___Korean
___Chinese
___Arabic
___Other _________________________________

Signature of Patient: _______________________________ **Date:** ________________________
(or Parent/Guardian if a minor)

Eye Physicians and Surgeons, PC

Patient's name: ______________________________________ Date: _________________

Date of birth: ____________

Patient Acknowledgment of Notice of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that Eye Physicians & Surgeons, PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. Eye Physicians & Surgeons, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Eye Physicians & Surgeons, PC has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

I give Eye Physicians & Surgeons, PC permission to discuss my health information with the following individual(s):

Name	Relationship	Phone Number

May we contact in case of emergency? Yes___ No ___

My signature below indicates that I have been given the chance to review a current copy of Eye Physicians & Surgeons, PC's "Notice of Privacy Practices" and gives permission to discuss my health information with individual(s) listed above.

_______________________________________ ____________________

Signature of Patient (or parent/guardian if a minor) **Date**

PHARMACY INFORMATION

(Information is necessary for new and refill prescriptions in order to electronically send to your pharmacy)

Name of Pharmacy (e.g. CVS, Walgreens, Wal-Mart, etc.) **Pharmacy Phone Number**

Street address **City** **State** **Zip**

(If you do not know the exact address of your pharmacy, please provide street name and city. With this information, we can locate your pharmacy by their phone number.)

Date:	Name:	Age	Date of Birth
	Primary Care Doctor's Name: First Last Phone#		

Medical History: REVIEW OF SYSTEMS

(Please indicate if any of the following medical conditions pertain to you)

Eyes:	YES	NO	**Constitutional:**	YES	N0
Glaucoma	☐		Development Disability	☐	
Cataract	☐		Unintended Weight Loss	☐	
Macular Degeneration	☐	☐	Persistent Fever	☐	☐
Inflammation	☐		Chronic Fatigue	☐	
Loss of Vision	☐		Trauma	☐	
Blurry Vision	☐		Other	☐	
Dry or Watery Eyes	☐				
Infections	☐				
Other	☐				
Cardiovascular	YES	NO	**Musculoskeletal:**	YES	NO
Heart Disease	☐		Muscle/Joint Pain	☐	
High Blood Pressure	☐	☐	Muscle Spasms	☐	
Stroke	☐		Muscle Weakness	☐	☐
Vascular Disease	☐		Muscle/Joint Swelling	☐	
Other	☐		Arthritis	☐	
			Other	☐	
Endocrine:	YES	NO	**Gastrointestinal:**	YES	NO
Diabetes	☐		Diarrhea	☐	
Hormonal Dysfunction	☐		Constipation	☐	
Cholesterol/Lipid Problems	☐	☐	Heartburn/Ulcer	☐	☐
Cancer	☐		Cancer	☐	
Other	☐		Other	☐	
Respiratory:	YES	NO	**Allergic/Immune:**	YES	NO
Emphysema	☐		Allergies	☐	
Pneumonia	☐		Rheumatoid Arthritis	☐	
Asthma	☐	☐	Lupus	☐	☐
Bronchitis/Cough	☐		Autoimmune Disease	☐	
Cancer	☐		Other	☐	
Other	☐				
Blood/Lymphatic	YES	NO	**Integumentary (skin)**	YES	NO
Anemia	☐		Eczema/Dermatitis	☐	
Bleeding Problems	☐	☐	Rosacea/Acne/Psoriasis	☐	
Leukemia	☐		Cysts/Warts/Ulcer	☐	☐
Other			Cancer	☐	
			Other	☐	
Nervous System:	YES	NO	**Mental:**	YES	NO
Seizures	☐		Depression	☐	
Multiple Sclerosis	☐		Panic/Anxiety Disorders	☐	
Headaches/migraines	☐	☐	Mood Changes	☐	☐
Paralysis	☐		Psychoses	☐	
Other	☐		Amnesia/Sleep Disorders	☐	
			Other	☐	
Ears/Nose/Throat	YES	NO	**Genitourinary Problems**	YES	NO
Runny Nose/Hay Fever	☐		Genital/Prostate	☐	
Sinus Congestion	☐		Kidney/Bladder	☐	
Dry Mouth/Throat	☐	☐	Ovary/Uterus/Vaginal	☐	☐
Cancer	☐		Cancer	☐	
Other	☐		Other	☐	

PATIENT NAME: ____ DATE _________________________

Social History:

Do you have visual difficulty when driving? YES□ NO□ If yes, please explain:_____________

____

Do you use tobacco products? YES □ NO □ If yes, type/amount/how long: ________________

Do you drink alcohol? YES □ NO □ If yes, type/amount/how long: ________________

Do you use addictive agents? YES □ NO □ If yes, type/amount/how long: ________________

Have you been infected with? ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over-the-counter medications and/or home remedies): YES □ NO □

If yes, please list:____

____

Have you had past injuries? If yes, please list:
YES □ NO □ ____

Have you had past surgery? If yes, please explain:
YES □ NO □ ____

Are you currently pregnant? If yes, expected due date:
YES □ NO □ ____

Are you allergic to any medications: YES □ NO □

If yes, please list: ____ __

____

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sisters, or children) has had any of the following conditions:

	YES	NO		YES	NO
Blindness	□	□	Diabetes	□	□
Cataract	□	□	Heart Disease	□	□
Crossed Eyes	□	□	High Blood Pressure	□	□
Glaucoma	□	□	Kidney Disease	□	□
Macular Degeneration	□	□	Lupus	□	□
Retinal Detachment/Disease	□	□	Thyroid Disease	□	□
Arthritis	□	□	Other	□	□
Cancer	□	□			

Patient Signature	Date	Initial if No Change

ROSPG2082511

List of Medications

Patient Name:___________________________________

Name of Medication	Dosage (Strength) (e.g. 50 mg)	How Often Taken (e.g. twice per day)

____
Patient Signature Date

Eye Physicians & Surgeons, PC, Atlanta Eyewear & Atlanta Lasik Center
Financial Policy

Our goal is to keep your insurance and/or other financial arrangements as simple as possible and to accomplish this in a cost effective manner. In order to achieve these goals, we need your assistance and your understanding of our financial policy. Please read and sign below.

- **You are ultimately responsible for payment of services you receive from our office.**
- Co-payments, co-insurance, deductibles and any non-covered services are collected at the time of service.
- **Certain procedures are non-covered services under insurance policies; therefore, payment for these non-covered services is required at the time of service unless payment arrangements have been made. Example: Refraction, CPT code 92015, is a service that must be performed in order for the physician to prescribe glasses. This service is generally considered routine eye care and not covered by insurance**.
- If a service is a non-covered service, there are no diagnosis codes that will cause your insurance to pay.
- We will process and file your health insurance claims for services at no cost to you.
- You are responsible for providing us with your current address, telephone number, email address and insurance information at each visit. **Failure to do so may result in non-payment by your insurance company and you will be responsible for payment of services that may be covered by insurance if the information had been provided by you.**
- Returned checks are subject to a $25.00 handling fee.
- **Unpaid accounts are sent for outside collections and you will be billed and are responsible for all additional fees involved in that process.**
- **Cancellation Fees** – **We require a 24-hour cancellation of your appointment.** If you fail to give a 24-hour cancellation notice, **you will be charged a $25 cancellation fee**, which must be paid prior to rescheduling your appointment.
- **No Show Policy – If two appointments result in No Shows, you will not be rescheduled a third time and the cancellation fees apply.**
- **Completion of Forms** – A fee is charged for the completion of forms, such as Disability, FMLA, ADA, School, Camp, Adoption, etc. The fee must be paid before the forms are completed. The cost varies, depending on the amount of time necessary for completion.
- **Copies of Medical Records** – We charge for the copying of medical records. The rates are based on the current Georgia guidelines for retrieval and copying medical records. These rates apply for all requests, whether requested by you, another physician's office, or any third party (except SSA.) An Authorization to Release Records Form must be completed and signed by you (the patient) before requests are processed. All retrieval and copy fees must be paid, before a request is processed

I acknowledge that I understand and accept this financial policy.

_________________________ _______________ _________________________
Signature Date Relationship to patient (if patient a minor)

____
Print Name

MEDICAL vs. VISION INSURANCE

One of the most challenging billing issues in an ophthalmology office is whether we should be billing the medical or vision plan.

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive, medical eye exams. However, ophthalmologists also provide routine vision exams for people with no eye disorders.

For Patients with BOTH Medical and Vision Coverage

Your vision insurance is intended to provide you with a baseline eye exam. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care. Typically your vision company does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance **for visits related to medical complaints and problems. (**If we are participating in your vision plan, your exam will be filed as a secondary claim to your vision plan after your medical plan completes the claim.)

For Patients without Vision Coverage

If you are being seen for a routine eye exam and do not have vision coverage, your medical insurance **will not** pay for the exam. However, if you have a medical problem (corneal disorders, diabetes, a lazy eye, cataracts, glaucoma suspect, double vision, etc.), your visit is considered a medical problem and can be billed to your medical plan.

Please be aware that many medical plans are no longer paying for eye exams because of a diagnosis of blurred vision or a headache. They are considering this a routine vision exam and are often not paying for the exam.

Our billers will determine the appropriate plan (medical or vision) to file your claim, based on the results of your exam.

When your visit is for a routine eye evaluation, we collect the total fee at the time of service unless we participate with your vision plan. If we are participating (with your vision plan), we will follow your plan’s guidelines collecting applicable copay and/or co-insurance at the time of service.

Authorization for Use/Release of Health Information

TO: ____

Name of Physician or Organization requesting records from:

ADDRESS:____

City **State** **Zip**

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize Eye Physicians & Surgeons, PC to obtain the protected health information described below. This information should be mailed or faxed to:

Eye Physicians & Surgeons, P.C. FAX #: (404)294-9361
1457 Scott Blvd.
Decatur, GA 30030

Please send this information on or about (information will not be resent without another authorization): ___/____/____
This authorization expires upon fulfilment of request unless special circumstances noted below ** Mo Day Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):____________________________

I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/____ to ___/___/____
Mo Day Year Mo Day Year

___ Copies of the information described below for period ___/___/____ to ___/___/____

___ History & Physical Examination ___ Lab, X-ray, etc. Reports ___ Reports from Other Physicians

___ Other (Please Specify)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during dates above –
____

** Please describe any special requirements such as Faxing, certified mail, extended expiration date, and the like –

____

I understand that there may be information in these records that I would not want released.

I have been provided a copy of Eye Physicians & Surgeons, PC *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Eye Physicians & Surgeons, PC's Privacy Officer or other appropriate office personnel.

I understand that Eye Physicians & Surgeons, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Eye Physicians & Surgeons, PC from all legal liability that may arise from this authorization.

Patient's Signature ____**Date** ____________________________

Print Patient's Name ____

SS# ____________________________ DOB:___________________

If the signature above is not that of the patient, I am acting for the patient because ____________________________________

My relationship to the patient is: ____________________________. Signed ____________________________________

The patient or their representative may revoke this authorization by notifying in writing Eye Physicians & Surgeons, PC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.