

*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 _____	___ Email _____
___ Mobile phone _____	___ Secure Email _____
___ Work phone _____	___ U.S. Mail _____
___ Other phone _____	

Ethnicity:

___ Hispanic	___ Unknown
___ Non-Hispanic	___ Decline to answer

Race:

___ American Indian/Alaska Native	___ Native Hawaiian/ Other Pacific Islander
___ Asian	___ White/Caucasian
___ Black/African American	___ Decline to answer

Primary/Preferred Language:

___ English
___ Spanish
___ French
___ Korean
___ Chinese
___ Arabic
___ Other _____

Signature of Patient: _____
(or Parent/Guardian if a minor)

Date: _____

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
_____	_____	_____
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:			Phone#	
First Last					
Medical History: REVIEW OF SYSTEMS					
(Please indicate if any of the following medical conditions pertain to you)					
Eyes:		YES	NO	Constitutional:	
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:	
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:	
Diabetes		☐		Diarrhea	
Hormonal Dysfunction		☐		Constipation	
Cholesterol/Lipid Problems		☐	☐	Heartburn/Ulcer	
Cancer		☐		Cancer	
Other		☐		Other	
Respiratory:		YES	NO	Allergic/Immune:	
Emphysema		☐		Allergies	
Pneumonia		☐		Rheumatoid Arthritis	
Asthma		☐	☐	Lupus	
Bronchitis/Cough		☐		Autoimmune Disease	
Cancer		☐		Other	
Other		☐			
Blood/Lymphatic		YES	NO	Integumentary (skin)	
Anemia		☐		Eczema/Dermatitis	
Bleeding Problems		☐	☐	Rosacea/Acne/Psoriasis	
Leukemia		☐		Cysts/Warts/Ulcer	
Other				Cancer	
				Other	
Nervous System:		YES	NO	Mental:	
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	
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

List of Medications

Patient Name: _____

[illegible]

Patient Signature	Date
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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 fulfillment 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.