Georgia Eye

## Patient Information

***How did you hear about us?***

▫ Dr. Crosby Patient ▫ Doctor Referred ▫ Another Patient ▫ Internet Search
▫ Staff Member ▫ Word of Mouth ▫ Insurance Co. ▫ Other _____

**Prefix (circle one) Mr. Mrs. Miss. Ms. Dr.**

**First Name _____ Middle _____**

**Last Name _____**

**Suffix (Jr., Sr., III, etc.) _____**

**Nickname _____**

**Gender (circle one) Male Female**

**Date of Birth _____**

**SSN _____**

**Maiden/Previous Name_____**

**Address _____**

**Zip _____**

**State _____ City _____**

**Is someone other than the patient responsible for the bill (such as a parent) ▫ Yes ▫ No**

**If YES, name _____**

**Phone _____**

**Relationship _____**

**Address _____**

_____

**Phone Numbers**

**Home _____**

**Mobile _____**

**Work _____**

**Other _____**

**E-mail _____**

**You authorize us to text or leave a message on the numbers above or email you unless noted here:**

_____

**Primary Number ▫ Home ▫ Mobile ▫ Work**
**Secondary Number ▫ Home ▫ Mobile ▫ Work**

**▫ Opt out of automated appointment reminders**

**Referred by _____**

**Primary Care Doctor_____**

**Race _____**

**▫Single ▫ Married ▫ Widowed ▫ Divorced ▫Minor**

**Are you Hispanic or Latino ▫ Yes ▫ No**

**Language ▫ English ▫ Spanish ▫ _____**

**Emergency Contact** _____ **Employer** _____

**Relationship** _____ **Phone** _____ **Occupation** _____

▫ **Employed** ▫ **Full time student** ▫ **Homemaker** **Address** _____
▫ **Part time student** ▫ **Retired** ▫ **Unemployed**

***Please provide your insurance cards at check in.***

**Primary Medical Insurance** _____

**Secondary Medical Insurance** _____

**Vision Insurance** _____

**Were you injured on the job?** ▫ **Yes** ▫ **No** **If yes, date of injury** _____

**Did you report the injury to your employer?** ▫ **Yes** ▫ **No**

**Authorization and Assignment:**
**I authorize Georgia Eye, LLC to release medical records to any insurance company with whom I have medical or vision benefits, or to my employer, for the purpose of filing medical claims. I also authorize any physician, hospital, or clinic to provide medical information required in the course of my examination or treatment. I give consent for Georgia Eye, LLC physicians to obtain prescription history from external sources.**

**I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative.**

**Insurance is filed as a courtesy. It is the patient/guardian responsibility to ensure all bills are paid. All co-pays, deductibles, and co-insurance are due at the time of services. Surgical estimates are due a week prior to surgery.**

**Assignment of Benefits Payment: I authorize my health insurance benefit plan to pay directly to Georgia Eye. I understand that I am financially responsible for any non-covered charges. If I am a self-pay patient, I understand that I am responsible for all charges in full at the time of service. I have read and understood the Financial Policy terms and conditions effective 1/2/2020.**

**I acknowledge I have received the Notice of Privacy Practices and Notice of Individual Rights. Georgia Eye may release information to the following people:**

| **Name** | **Relationship** | **Phone Number** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Patient or Guardian Signature** _____ **Date** _____

Georgia Eye

# Financial Policy

Thank you for choosing Georgia Eye, LLC to serve your eye care needs. We are dedicated to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is vital to our professional relationship. Your payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, and your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

We participate with many insurance plans. It is your responsibility to check with your insurance company to be sure we participate with your plan and for details about your benefits.

## Insurance Claims

Please bring your insurance cards to every visit. In order to accurately bill your insurance company we require that you provide accurate and current insurance information including primary and secondary insurance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company possibly will pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we do not participate with your plan, you will be responsible for your responsibility under out of network benefits which may be full payment.

## Vision Plans

We participate with some Vision Plans. Please check with your plan to see if we are members of your Vision Plan. If we do not participate, services are payable at the time of service.

## Co-payments, Deductibles and Co-Insurance

Patients are expected to pay AT TIME OF SERVICE all amounts known not to be covered by their insurance company. These amounts include co-payments, co-insurance and/or deductibles. Payments may be made by cash, check, and/or credit card. Surgical estimates are due one week prior to surgery.

## Self Pay Discounts

Self-pay discounts are for patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without any insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If you come for an office visit and we do not participate with your insurance company, we assume you decided to see us as an out-of-network provider. The discount is offered as a courtesy because we do not have to send statements or track payments since payment in full is expected at the time of service. The discount applies only to physician services and does not apply to any products we sell, including but not limited to eyeglasses and contact lenses.

The discount does not apply to patients who have not met their deductible. It also does not apply to patients who are eligible to receive direct reimbursement from an insurance plan. The discount does not apply to the refraction fee. Any unpaid charges are not eligible for the discount.

## Routine vs. Medical Exam

A Routine Vision Exam is a screening exam which is performed as a “healthy” visit. It is most frequently requested by patients to determine the need for corrective lenses. Not all insurances cover screening exams or offer a “vision” benefit. It is your responsibility to know if you have this benefit and how often it may be available. You will be responsible for payment if your vision exam is not covered. A medical exam is billed to your medical insurance with the symptom or condition which was examined on the day of the visit.

## Refraction

This is the test to determine if you need a prescription for eyeglasses. Unfortunately most insurance companies do not pay this fee, it is billed to the patient in addition to the exam charge and is payable at the time of service. Our Refraction fee is $40.00.

## Financing

Care credit is a financing option that may be available for patient balances over $1,000.00.

## Workers’ Compensation

In the case of a workers’ compensation, you must obtain the claim number, phone number, contact person, name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

## Returned Checks

The charge for a returned check is $25.00 payable only by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

## Minors

The parent(s) or guardian(s) who accompanies the minor is responsible for full payment and will receive the billing statements.

## Outstanding Balances

If your account becomes delinquent and you have not established or met payment options with our billing department, your account will be turned over to a collection agency. Outstanding balances must be resolved prior to any non-emergency appointments. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing department to discuss payment options. Our staff is always available to listen and help.

This Financial Policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at (706) 546-0170.