Georgia Eye
ATHENS | GREENSBORO | COMMERCE

Welcome! How did you find us?

Previous Patient | Google

Referred by Dr. _____ | Insurance Co. | Staff Member_____

Friend/ Family_____ | Drove by | Other _____

Patient Information

Prefix: Mr. Mrs. Miss. Ms. Dr.

First Name _____ **Middle** _____

Last Name _____

Nickname _____

Gender: Male / Female

Date of Birth _____

SSN _____

Maiden/Previous Name_____

Address _____

Zip _____ **State** _____ **City** _____

Home Phone:_____

Cell Phone:_____

Work/ Other:_____

E-mail _____

Do you authorize us to text, email or leave a message on the numbers and email address listed above? Yes / No

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

If YES, Name _____

Phone _____**Relationship** _____

Address _____

Zip _____ **State** _____ **City** _____

Primary Care Physician_____

Race _____

Single / Married / Widowed / Divorced / Minor

Ethnicity: _____

Language: English / Spanish / _____

Emergency Contact

Name:_____

Relationship: _____

Phone Number:_____

Employment

Employed / Retired / Student -Full or Part time /

Homemaker / Unemployed

Employer_____

Occupation _____

Insurance Information

Please provide your insurance cards at check in.

Medical Insurance: _____

Policy Number: _____

Secondary Insurance: _____

Policy Number: _____

Vision Insurance: _____

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. Self-pay patients must pay charges on the date of services. Surgical estimates are due fourteen days prior to surgery. If payment is not received fourteen days prior to surgery date, the appointment will be canceled.

Medical Testing: Additional testing may be deemed necessary by your provider to diagnose, monitor, and/ or treat your medical eye conditions. Charges for these tests are separate from the exam charge and will be submitted to your insurance. Your responsibility for the testing will be based upon your individual benefit plan and the processing of these charges by your insurance. You will be asked to pay at check out for these additional tests and may be billed for any portion deemed your responsibility or not paid by your insurance company.

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.Vision insurance only provides a baseline wellness exam of the eye for patients with no eye disorders. If you have an eye disorder or medical condition that requires more than a wellness exam your visit will be filed to your medical insurance. Our Ophthalmologists Dr. Centrael Evans, Dr. Stephanie Lynch and Dr. Tirth Shah typicaly only file medical insurance for most exams. Should you want to file only to your vision policy, your exam must be routine in nature and not have any medical complaints or diagnosis. You may still file any material benefits for glasses or contact lenses through Eyemed or VSP with our optical department regardless of which physician you see for your exam.

Assignment of Benefits Payment: I authorize my health insurance benefit plan to pay directly to Georgia Eye or Eye Specialists of America, LLC -a subsidiary of Georgia Eye.

Identification: We do ask that you provide us with a photo ID and your insurance cards at check in. This helps us to identify you and make it possible to file your insurance. We may ask for identification and insurance cards at each visit.

Check Policy: We will gladly accept your personal check, however, our returned check fee is $25.00.

I understand that I am financially responsible for any non-covered charges or outstanding balances. 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 understand the Financial Policy terms and conditions effective 1/2/2020.

I acknowledge I have received the Notice of Privacy Practices, Financial Policy and Notice of Individual Rights. I acknowledge the policies above. **Georgia Eye may release information to the emergency contact listed on your records and to the following people:**

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Patient or Guardian Signature _____ **Date** _____

Full Name _____ DOB _____

Preferred Pharmacy _____ _____ _____
Name Street City

Current/prior Occupation: _____

Were you injured on the job? Yes / No / N/A **Date of injury**: _____ **Injury reported to employer?** Yes / No

I wear:

- ☐ No glasses
- ☐ Prescription glasses
- ☐ Over-the-counter readers
- ☐ Contact lenses

Do you want a prescription update today?

- ☐ YES (fee up to $40 may apply depending on insurance)
- ☐ NO

Past Eye Conditions

☐ None

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Dry Eye
- ☐ High eye pressure
- ☐ Macular degeneration
- ☐ Diabetic eye disease
- ☐ Iritis/Uveitis (inflammation in the eye)
- ☐ Keratoconus
- ☐ Retinal tear
- ☐ Retinal detachment
- ☐ Artery or vein occlusion ("stroke" in the eye)
- ☐ Strabismus (crossed eyes)
- ☐ Eye patching as a child
- ☐ Other: _____

Past Eye Injuries

☐ None ☐ YES (provide details): _____

Eye Medications (drops/vitamins)

☐ None ☐ YES (list names): _____

Past Eye Surgeries

- ☐ None
- ☐ Cataract surgery
- ☐ Laser to clean artificial lens (YAG)
- ☐ Injections
- ☐ Glaucoma laser (ALT, SLT)
- ☐ Laser to iris (LPI or LI)
- ☐ Glaucoma surgery
- ☐ Cornea transplant
- ☐ LASIK / laser vision correction
- ☐ Retina laser
- ☐ Retina surgery
- ☐ Strabismus surgery
- ☐ Other: _____

Current & Past Medical Conditions

- ☐ None
- ☐ Hypertension (high blood pressure)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Heart disease
- ☐ Heart attack
- ☐ Arrhythmia (heart rhythm abnormality)
- ☐ Cancer - specify type & year of diagnosis: _____
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Stroke
- ☐ TIA (mini-stroke)
- ☐ Dementia
- ☐ Migraines
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Asthma
- ☐ COPD (emphysema)
- ☐ Sarcoidosis
- ☐ Acid reflux (heartburn)
- ☐ Stomach ulcer
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Kidney disease
- ☐ Dialysis
- ☐ Prostate enlargement
- ☐ Osteoarthritis ('wear-and-tear' arthritis)
- ☐ Rheumatoid arthritis

- ☐ Lupus
- ☐ Other autoimmune disease
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Substance use disorder
- ☐ Thyroid disease
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ HIV
- ☐ Syphilis
- ☐ Tuberculosis
- ☐ Other:

_____

_____

_____

Past Surgeries

- ☐ Coronary bypass
- ☐ Coronary stent
- ☐ Tonsillectomy
- ☐ Mastectomy
- ☐ Spine surgery
- ☐ Gallbladder removal
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ C-section
- ☐ Hysterectomy
- ☐ Prostate surgery
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Other:

_____

_____

_____

List Current Prescription & OTC Medications:

_____

_____

Drug Allergies: _____

Family History of Eye Problems (check boxes):

☐ None

	Mom	Dad	Sibling	Child	Aunt/Uncle	Grandparent
Glaucoma						
Macular degeneration						
Retinal detachment						
Blindness (any cause)						
Other						

Other Health Information:

Current tobacco use:	Yes	No
Past tobacco use:	Yes	No
If diabetic, last morning blood sugar:	_____	
If diabetic, hemoglobin A1c (blood draw):	_____	
Any falls in the last year?	Yes	No
Have you had a flu vaccine in the last 12 mos.?	Yes	No
Over age 65: Have you had a pneumonia vaccine?	Yes	No

Patient/Guardian **Signature:** _____ **Date:** _____

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.

Identification

We do ask that you provide us with a photo ID and your insurance cards at check in. This helps us to identify you and make it possible to file your insurance. We may ask for identification and insurance cards at each visit.

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.

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.

Co-payments, Deductibles and Co-Insurance

Insurance is filed as a courtesy. It is the patient/ guardians responsibility to ensure all bills are paid. All co-pays, deductibles, and co-insurance are due at the time of services. Self-pay patients must pay charges on the date of services. Surgical estimates are due fourteen days prior to surgery. If payment is not received fourteen days prior to surgery date, the appointment will be canceled.

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.

Medical Testing

Additional testing may be deemed necessary by your provider to diagnose, monitor, and/ or treat your medical eye conditions. Charges for these tests are separate from the exam charge and will be submitted to your insurance. Your responsibility for the testing will be based upon your individual benefit plan and the processing of these charges by your insurance. You will be asked to pay at check out for these additional tests and may be billed for any portion deemed your responsibility or not paid by your insurance company.

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.Vision insurance only provides a baseline wellness exam of the eye for patients with no eye disorders. If you have an eye disorder or medical condition that requires more than a wellness exam your visit will be filed to your medical insurance. Our Ophthalmologists Dr. Centrael Evans, Dr. Stephanie Lynch and Dr. Tirth Shah typicaly only file medical insurance for most exams. Should you want to file only to your vision policy, your exam must be routine in nature and not have any medical complaints or diagnosis. You may still file any material benefits for glasses or contact lenses through Eyemed or VSP with our optical department regardless of which physician you see for your exam.

Routine vs. Medical Exam

A Routine Vision Exam is a screening exam which is performed as a “healthy” visit for no specific illness, symptom, complaints or injury that needs to be treated or diagnosed. It is most frequently requested by patients to determine the need for glasses or contact 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. The physician will determine if the examination meets requirements to be filed routinely or medically based on patient symptoms, complaints and diagnosis at their 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.

Assignment of Benefits Payments

I authorize my health insurance benefit plan to pay directly to Georgia Eye or Eye Specialists of America, LLC -a subsidiary of Georgia Eye.

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.

I understand that I am financially responsible for any non-covered charges or outstanding balances. 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 understand the Financial Policy terms and conditions effective 1/2/2020.

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.