NEW PATIENT MEDICAL HISTORY RECORD

Name: _____ **Date:** _____

PAST EYE HISTORY (List any diagnosed eye illness or surgeries) _____
_____

CURRENT EYE MEDICATIONS (List all eye drops or ointments) _____
_____

PAST MEDICAL HISTORY

	YES	NO		YES	NO
TUBERCULOSIS	____	____	HIGH BLOOD PRESSURE	____	____
CANCER	____	____	KIDNEY DISEASE	____	____
DIABETES	____	____	THYROID DISEASE	____	____
BLOOD DISORDERS	____	____	LUNG DISEASE	____	____
HEART DISEASE	____	____	NEUROLOGICAL DISORDERS	____	____

OTHER (DESCRIBE)_____
_____
MAJOR SURGERIES (DESCRIBE)_____
_____

MEDICATIONS (List all medications including Oral, Prescription, Topical, Injections, OTC, Vitamins, and Homeopathic/Herbal Medications)
_____
_____
_____

ALLERGIES (List all known Drug, Substance, or Ocular allergies)_____
_____

FAMILY HISTORY (Please list any family history of eye diseases or illnesses)_____
_____

SOCIAL HISTORY
DO YOU SMOKE? ( ) YES ( ) NO HOW MUCH?_____
DO YOU DRINK ALCOHOL? ( ) YES ( ) NO HOW MUCH?_____
HAVE YOU EVER USED DRUGS? ( ) YES ( ) NO IF YES, EXPLAIN_____
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ( ) YES ( ) NO

REVIEW OF SYSTEMS (Do you have any of the following problems? If so, please circle which one)

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE ( ) YES ( ) NO _____
EAR/NOSE/THROAT PROBLEMS (hearing loss, sinus problems, etc) ( ) YES ( ) NO _____
HEART PROBLEMS (chest pain, irregular heart beat, etc) ( ) YES ( ) NO _____
RESPIRATORY PROBLEMS (shortness of breath, wheezing, coughing) ( ) YES ( ) NO _____
GASTROINTESTINAL PROBLEMS (heartburn, abdominal pain, etc) ( ) YES ( ) NO _____
URINARY PROBLEMS (pain or discomfort, blood in urine, etc) ( ) YES ( ) NO _____
SKIN PROBLEMS (rashes, excessive dryness, etc) ( ) YES ( ) NO _____
MUSCULOSKELETAL PROBLEMS (muscle aches, joint pain, etc) ( ) YES ( ) NO _____
NEUROLOGIC PROBLEMS (numbness, weakness, headaches, paralysis) ( ) YES ( ) NO _____
PSYCHIATRIC PROBLEMS (depression, anxiety, etc) ( ) YES ( ) NO _____
ALLERGIES (hay-fever, sinus problems, runny nose, etc) ( ) YES ( ) NO _____
Completed By: _____ Relationship: _____

HISTORY REVIEWED ( ) CHANGES ( ) CHANGES AS NOTED - PHYSICIAN: _____ DATE:_____

GEORGIA EYE PHYSICIANS AND SURGEONS
WILLIAM A. SEGAL, MD

LIFESTYLE QUESTIONNAIRE

- Do you currently wear glasses? _____ If yes, how long? _____
- How many pairs of glasses do you have for different uses? (Example: reading, golf, computer, sunglasses, sports, distance, etc.) 1 2 3 4 5
  - Did you bring your sunglasses with you today? Yes / No
  - Are you interested in getting a new pair of sunglasses? Yes / No
- Do you currently wear contact lenses? _____ If yes, how long? _____

  Type of contacts worn (disposable, toric, rigid gas permeable): _____

  Brand of contacts worn (Acuvue, Bausch & Lomb, Ciba): _____

  How many hours a day do you typically wear your contact lenses? _____

  For disposable contact lens wearers, how often do you replace your lenses? _____

  _____
- Do you work on a computer? _____ If yes, how many hours per day? _____

  Do you experience eye fatigue while on the computer (rubbing eyes, tearing, etc.)?

  If yes, describe: _____
- Do you experience a stiff neck by the end of the day? _____
- Do you tilt your head to view the computer screen through your bifocals? _____
- What hobbies do you actively participate in? _____

  _____
- What sports do you actively participate in? _____

  _____
- Do you have difficulty driving at night? _____If yes, describe: _____

  _____
- Are you interested in learning how to eliminate your need for glasses or contacts? _____
- Are you interested in Laser Vision Correction (Blade-free LASIK)? _____
- Have you ever used medication for prostate hypertophy/enlarged prostate? Yes / No / Not sure

Signature: _____ Date:_____

PATIENT INFORMATION

PATIENT NAME:_____
(Last) (First) (MI)

ADDRESS: _____
(Street/PO Box) (Apt #)

_____
(City) (State) (Zip)

HOME PHONE: _____ CELL PHONE: _____

PATIENT SEX: ( ) MALE ( ) FEMALE DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: _____ SOCIAL SECURITY NO: _____

EMPLOYER: _____ EMAIL ADDRESS_____

OCCUPATION: _____ BUSINESS PHONE: _____

REFERRING DOCTOR:_____ PHONE:_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

CARDIOLOGIST:_____ PHONE:_____

PERSON TO NOTIFY IN AN EMERGENCY: _____
(Name) (Phone)

PRIMARY INSURANCE INFORMATION

PLEASE FILL OUT COMPLETELY

INSURED'S NAME: _____ DATE OF BIRTH: _____

ADDRESS:_____ CITY/STATE/ZIP:_____

SOCIAL SECURITY NO:_____ SEX: ( ) MALE ( ) FEMALE

EMPLOYER NAME/AND PHONE: _____

SECONDARY INSURANCE INFORMATION

INSURED'S NAME: _____ DATE OF BIRTH: _____

ADDRESS:_____ CITY/STATE/ZIP:_____

SOCIAL SECURITY NO:_____ SEX: ( ) MALE ( ) FEMALE

EMPLOYER NAME/AND PHONE : _____

OTHER INSURANCE INFORMATION

Do you have a separate vision carrier (i.e. VSP, Superior Vision, EyeMed, Vision Care Plan)? ☐ Yes ☐ No
If yes, please list plan name:_____
Please Note: Many vision plans require a preauthorization that is unobtainable after the date of service. Therefore, if we do not have prior knowledge of your separate vision plan, we will not be able to file a claim.

PLEASE BE ADVISED: WE FILE INSURANCE CLAIMS AS A COURTESY FOR OUR PATIENTS, BUT IT IS YOUR RESPONSIBILITY TO KNOW THE SPECIFIC DETAILS OF YOUR PLAN. PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT IN ORDER TO: (1) VERIFY THE PHYSICIAN IS A PARTICIPATING PROVIDER, (2) CHECK REFERRAL STATUS (IF REQUIRED), AND (3) DETERMINE IF YOU HAVE MET YOUR REQUIRED DEDUCTIBLES.

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any non-covered services or unpaid balance and any legal fees necessary to collect the unpaid balance. I also authorize my physician to release any information required in processing these benefits.

PATIENT SIGNATURE: _____DATE: _____

TERMS AND CONDITIONS

Routine Vision Exam vs. Comprehensive Medical Exam:

At Georgia Eye Physicians and Surgeons, we perform two distinct levels of eye examination: a ROUTINE VISION EXAM and a COMPREHENSIVE MEDICAL EXAM. During a ROUTINE VISION EXAM the eyes are examined only for any necessary correction and for potential indicators of eye disease. The more thorough COMPREHENSIVE MEDICAL EXAM involves the diagnosis, treatment, and management of conditions such as cataracts, glaucoma, diabetic retinopathy, macular degeneration, and many other potentially sight-threatening diseases or injuries. COMPREHENSIVE MEDICAL EXAMS are treated like any other MEDICAL exam and will be filed with your medical insurance carrier. The type of eye exam you will be given is determined by the reason for your visit or your chief complaint, as well as by your diagnosis. ROUTINE VISION EXAMS usually produce a final diagnosis such as nearsightedness or astigmatism, while COMPREHENSIVE MEDICAL EXAMS produce diagnoses such as "glaucoma" or "cataracts."

Your Eye Examination

A complete eye exam, whether it is a ROUTINE VISION EXAM or a COMPREHENSIVE MEDICAL EXAM, consists of two parts:

1. Refraction – This is where the doctor examines your eyes to determine whether you need glasses, or if the prescription in your current glasses needs to be changed.

2. Medical Exam – This may be a cursory or more thorough examination where the doctor evaluates your eyes for a variety of eye diseases and conditions.

Refraction

Please be aware that if we are filing a medical insurance claim for today's visit, medical insurance typically considers the refraction to be "routine vision" and so this portion of the exam is usually NOT covered (unless you specifically have routine vision coverage under your medical insurance). The cost of the refraction is $35.00, due at the time of service. Cataract surgery patients will receive two (2) refractions, one before surgery and one after surgery, and there will be a $35.00 charge due for each of those refractions at the time of service.

Please check one of the boxes below:

- ☐ I want a refraction today.

- ☐ I do not want a refraction today (Please be aware that there may be cases in which a refraction will be necessary in order to complete a medical diagnosis).

By signing below, you are acknowledging that you have read and understand the information provided above. Please be sure that, if you have any questions or concerns, you address them with our staff prior to your appointment.

Signature: _____ Date:_____

Full Printed Name: _____

UNDERSTANDING YOUR OPTIONS: ROUTINE VISION VS. COMPREHENSIVE MEDICAL EXAMS

TEST	DESCRIPTION	ROUTINE VISION EXAM	COMPREHENSIVE MEDICAL EXAM
Visual Acuity Tests	Uses a projected eye chart and varying lenses to measure your close and long range visual acuity	X	X
Color Blindness Test	Detects hereditary color blindness and alerts us to possible eye health problems that may affect your color vision.		X
Cover Test	Checks how well your eyes work together in order to detect strabismus or other binocular vision problems that could cause eye strain or amblyopia (“lazy eye”).		X
Retinoscopy	Allows us to observe the way light reflects from the eye in order to evaluate refractive errors or astigmatism.		X
Refraction Tests	Determines your exact level of hyperopia (farsightedness), myopia (nearsightedness), astigmatism and presbyopia so that we can formulate the correct prescription for eyeglasses or contact lenses.	X	X
Slit-Lamp Examination	Allows us to get a magnified view of the structures of your eye so that we can thoroughly evaluate your eye health and detect signs of infection or diseases like glaucoma, cataracts, and retinopathy.		X
Glaucoma Test	Uses a small puff of air to measure the pressure in your eyes in order to help us determine whether you have glaucoma.		X
Visual Field Test	Checks for the presence of blind spots (scotomas) in your peripheral or “side” vision which can originate from eye diseases such as glaucoma.		X
Fundus Photos	Digital images of the interior of the eye that are painlessly captured using specialized photographic equipment to detect abnormalities of the retina, vitreous, choroid, and optic nerve.		X
External Eye Photography	Pictures of the eye taken with a high-resolution digital camera are used to gauge the progression of skin conditions that can affect the eye area such as eyelid lesions, rosacea, blepharitis, or skin cancer.		X

Note that every patient has their own specific vison health requirements, and some symptoms that may be observed during an examination could prompt a need for additional diagnostic tests. The final price of any eye examination is subject to change depending on the number of specific tests that are performed.

FINANCIAL AND PAYMENT POLICIES

Today, we have you scheduled for either a ROUTINE VISION EXAM or a COMPREHENSIVE MEDICAL EXAM. The following is a list of important terms and policies that you will need to understand prior to your appointment.

Insurance

We file insurance claims as a courtesy to our patients, but it is your responsibility to contact your insurance company prior to your appointment in order to verify network participation and referral requirements. Our front office staff can only provide general network participation information and so cannot be responsible for a guarantee of participation in your specific network. Please be advised that we are currently not a participating provider for most insurance plans purchased through the healthcare exchange.

Please check one of the boxes below:

- ☐ I have contacted my insurance carrier to verify network participation.
- ☐ I have contact my insurance carrier to verify referral requirements (If your plan requires a referral to see specialist, you must bring your referral with you to your appointment. Failure to do so may result in you being responsible for payment in full).
- ☐ I have not contacted my insurance carrier to verify network participation. (Failure to do so may result in you being responsible for payment in full if insurance is out of network.)

Payment

We understand the hardship medical bills can have on patients. In the event that you are unable to pay your balance in full upon receipt of your initial statement, we do allow for you to make monthly payments provided the balance is paid in full within 90 days. If you are unable to pay the balance within 90 days, we will require you to set up automatic, recurring payments through our secure credit card terminal. By signing below, you are acknowledging and agreeing to the following:

"I agree that the entity, Georgia Eye Physicians and Surgeons, or any other collection or servicing agency or agencies retained by the entity (together referred to hereafter as "collectors") in order to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact using e-mail at any e-email address I provide to the facility or otherwise associated with my account."

Coverage by Medical Insurance vs. Vision Insurance

Benefits under most vision plans are limited to the services provided by an ophthalmic or optometric provider that are needed in order to evaluate your need for glasses/contact lenses or to adjust the prescription for your eyewear. This ROUTINE VISION EXAM will be billed to the vision insurance plan and is not intended to evaluate the complete medical health of your eyes. A COMPREHENSIVE MEDICAL EXAM is done in response to a complaint from the patient about an eye problem or a decrease in visual acuity. The purpose of the COMPREHENSIVE MEDICAL EXAM is to diagnosis, treat, and/or manage any medical conditions or diseases of the eye. The way your eye exam is submitted to your insurance carrier(s) will depend not only upon what you tell the doctor, but also what the doctor finds upon examination.

By signing below, you are acknowledging that you have read and understand the information provided above. Please be sure that, if you have any questions or concerns, you address them with our staff prior to your appointment.

Signature: _____ Date:_____

Full Printed Name: _____

GEORGIA EYE PHYSICIANS AND SURGEONS
WILLIAM A. SEGAL, MD

CONTACT LENS EXAM CHARGES, FITTING FEES, AND AGREEMENT

	EXISTING WEARER	FIRST TIME WEARER
SOFT SPHERICAL	$50.00	$75.00
SOFT TORIC/COLORS	$100.00	$125.00
SOFT BIFOCAL/MONOVISION	$100.00	$125.00
GAS PERMEABLE SPHERICAL	$125.00	150.00
GAS PERMEABLE KERATOCONUS/CUSTOM/BIFOCAL	$250.00 or more NON REFUNDABLE	$250.00 or more NON REFUNDABLE

THE FITTING FEE INCLUDES:

1. A health examination of the eyes.
2. An instruction session on how to insert and remove your contact lenses (first time wearer) and instructions on the proper care of the lenses.
3. Continuing contact lens wears are required to return yearly to insure that your contact lenses are still properly fitting and providing you with the highest quality vision, comfort and health. There is an annual contact lens examination fee.
4. Soft contact lens fittings include the following:
    a.) One no-charge follow-up visit within 30 days to check the contact lens fit.
    b.) After one no-charge follow-up visit the charge is $30.00 for each of the next 2 visits within 30 days.
    c.) After 30 days the charge is $40.00 for each of the next 2 visits.
5. Gas permeable/Keratoconus contact lens fittings **not covered by insurance** include the following….
    a.) Three no-charge follow-up visits
    b.) After three no-charge follow-up visits the charge is $50.00 for each additional visit.
    c.) RGP/ Keratoconus contact lens wears must purchase their contacts from Georgia Eye Physicians and Surgeons.
6. Payment for all contact lens services is required at the time of service. Payment for the contact lenses may be required before the prescription is finalized.
7. **All fees must be paid, in full, prior to any contact lens fittings for medically necessary Keratoconus contact lenses. You may file with your insurance carrier for reimbursement**. Any overpayments made by your insurance carrier will be refunded to you upon receipt of payment from your insurance carrier. Any lenses purchased are to be paid for, in full, at the time of service.
8. It is not always possible to determine in advance whether a person will become a successful wearer. There are no guarantees and the exam and contact lens fitting fees are not refundable for any reason.

PATIENT RESPONSIBILITY

It is the patient's responsibility to pay the contact lens fitting fee in addition to the contact lenses. Contacts purchased may be exchanged for merchandise of equal or lesser value. No refunds after orders are placed and we are unable to exchange contact lens boxes if opened or written on.

CHECK ONE

☐ I want contact lenses today.

☐ I do not want contact lenses today.

Signature: _____ Date:_____

Full Printed Name: _____

GEORGIA EYE PHYSICIANS AND SURGEONS
WILLIAM A. SEGAL, MD

NO SHOW POLICY

TO SERVE OUR PATIENTS IN TIMELY MANNER WE DO NOT OVERBOOK. TIME IS ALLOWED FOR EACH APPOINTMENT. FOR THIS REASON WE ARE FORCED TO CHARGE A $50.OO FEE FOR NON-CANCELLATION OF A SCHEDULED APPOINTMENT (NO SHOW).

CONFIRMATION CALLS ARE MADE 24 TO 48 HOURS IN ADVANCE TO REMIND PATIENTS OF THEIR APPOINTMENT. MESSAGES WILL BE LEFT ON THE PATIENT'S PHONE WHEN POSSIBLE TO ALLOW TIME FOR THE PATIENT TO CANCEL THE APPOINTMENT.

A ONE-TIME CONSIDERATION MAY BE MADE FOR FAILURE TO SHOW UP FOR YOUR APPOINTMENT. ANY NO SHOWS AFTER THAT WILL BE CHARGED THE $50.00 FEE AND PAYMENT MUST BE MADE BEFORE ANOTHER APPOINTMENT IS SCHEDULED.

FEE FOR NO SHOW $50.00

I HAVE READ THE NO SHOW POLICY AND I UNDERSTAND THAT I WILL BE CHARGED IF I FAIL TO SHOW UP FOR MY APPOINTMENT AND I DID NOT CANCEL MY SCHEDULED APPOINTMENT.

_____
SIGNATURE

_____
PRINT NAME

_____
DATE

GEORGIA EYE PHYSICIANS AND SURGEONS
WILLIAM A. SEGAL, M.D

Authorization for Treatment

I hereby authorize *Georgia Eye Physicians and Surgeons* to provide necessary medical treatment.

Authorization for Release of Medial Information

I hereby authorize Georgia Eye Physicians and Surgeons to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job. I authorize *Georgia Eye Physicians and Surgeons* to discuss my health information with other providers and facilities in order to provide necessary medial treatment.

Assignment of Benefits

I hereby authorize payment of benefits directly to *Georgia Eye Physicians and Surgeons* for services provided. I understand that I am financially responsible to pay charges not covered by this assignment, including non-covered charges by my insurance carrier.

Authorization of Payment

Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment. I hereby agree to pay any outstanding balance and I agree to pay all reasonable cost of collection, including attorney fees, if any.

Authorization to Use Protected Health Information for Treatment, Payment, or Healthcare Operations:

I hereby give my consent for *Georgia Eye Physicians and Surgeons* to use and disclose protected health information (PHI) to carry out treatment, payment and healthcare operations. The "Notice of Privacy Practices" provides a more complete description of such uses and disclosure. I have the right to review the "Notice of Privacy Practices" prior to signing this consent. *Georgia Eye Physicians and Surgeons* reserve the right to revise its "Notice of Privacy Practices" at any time.

Authorization to Contact Me with Healthcare of Payment Information

With this consent, *Georgia Eye Physicians and Surgeons* may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist practice in carrying out TPO, such as appointment reminder, insurance inquiries, and any calls pertaining to my clinical care, including laboratory results among others. With this consent *Georgia Eye Physicians and Surgeons* may mail to my home or other alternative locations any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminder cards and statements. *Georgia Eye Physicians and Surgeons* may also email to my home or alternative location any items that assist in carrying out treatment, payment, or healthcare operations, such as appointment reminder cards and statements.

Rights:

I understand that I may revoke these authorizations at any time. I understand that *Georgia Eye Physicians and Surgeons* may decline to provide treatment if I do not sign this consent.

_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Patient's Name	Name of Legal Guardian