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:_____

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: _____

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 able to file a claim.

PLEASE BE ADVISED: INSURANCE CLAIMS ARE FILED AS A COURTESY FOR OUR PATIENTS. IT IS YOUR RESPONSIBILITY TO KNOW THE SPECIFICS OF YOUR PLAN. PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT TO: VERIFY THE PHYSICIAN IS A PARTICIPATING PROVIDER, CHECK REFERRAL STATUS (IF REQUIRED), OR IF YOU HAVE MET 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 noncovered 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.

DESIGNATED HIPAA RELEASE & COMMUNICATION

At my request, I authorize Georgia Eye Physicians & Surgeons to disclose my protected health information to:

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

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. Exam (Routine Vision or Comprehensive Medical) – 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 $40.00, 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 $40.00 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: _____

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. I understand that if I fail to pay my balance in full in a timely manner, my account may be referred to a 3rd-party collection agency, and a 28% collection fee will be added to 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 should be paid in full prior to any contact lens fittings for medically necessary Keratoconus contact lens/scleral contact lens. 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. A scleral lens may receive a partial material refund within 60 days of initial lens order minus a nominal restocking fee, after which time no refund will be given.
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). APPOINTMENTS MUST BE CANCELLED WITHIN 48 HOURS OF THE SCHEDULED APPOINTMENT TO AVOID THE NO SHOW FEE.

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.

ASSIGNMENT OF BENEFITS

I, _____ have healthcare benefits for medical necessity services through my employer (Employer Name) _____, Medicare, Medicaid or Individual Plan; including title XVIII of the Social Security Act or related provisions of title XI of the Act. I hereby appoint as my authorized representative, and assign to *Georgia Eye Physicians & Surgeons* and/or their designated business associate my rights, title, and interest in and to, and relating in and to the recovery of, any and all health care and/or surgical benefits otherwise payable to me or to receive coverage for medical care and/or benefits for which I am entitled to receive under my plan or policy, including major medical services rendered, ordered or requested by a healthcare provider as designated to render medical treatment or services. I specifically appoint as my authorized representative, *Georgia Eye Physicians & Surgeons* and/or their designated business associate to: file and prosecute any required appeal or grievance with my health plan and/or health insurer for any denial of medical tests, treatment or surgical care; receive benefit payment of medical claims or benefits submitted by or on behalf of my treating or medically related provider; file any required litigation or arbitration against my health plan and/or health insurer for any denial related to medical tests, treatment or surgical care or payment of pre or post-service medical claims submitted by my treating physician or other medically related provider; and to exert or receive any other rights or benefits entitled under my health plan or policy. I specifically authorize my authorized representative to name me and the patient, if I am executing this document on the patient's behalf, as plaintiffs in such litigation or arbitration against my health plan and/or health insurer or otherwise pursue claims on my behalf. I hereby also assign to *Georgia Eye Physicians & Surgeons* or other applicable medically related provider, any right wholly in my stead to recover its full billed charges and any expenses and fees incurred for pursuing my claim for benefits, as well as all rights, statutory or contractual, to any additional recovery related to my health benefits such as treble damages, punitive damages and/or penalties. This authorization includes the right to litigate under civil rights remedies provision of ERISA; Receive, release or discuss my personal health information or relevant medical records with my Plan Administrator, health plan and/or health insurer. I specifically authorize any law firm appointed by my authorized representative to file litigation or arbitration on my behalf and on behalf of my authorized representative with respect to any or all of the items listed above. I hereby authorize *Georgia Eye Physicians & Surgeons*, other medically related provider or facility, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any relevant records, documents, knowledge or information concerning my claim for benefits, my health, or request for medical treatment as it may relate to my pre or post service claim for benefits; to release such information to my authorized representative as appointed; to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of my claim for benefits. If any outside policies or consultants were used or relied on by my Plan or health insurer to perform an adverse benefit determination or in the handling of my pre or post service claim for benefits or any appeal requests, my health plan or health insurer is directed to provide my authorized representative with a legible copy of any said policy relied upon, all complete claim files, all investigative files, all relevant documents, data and communications associated with any pre-service or post-service claim for benefits and any appeals submitted, to include all names, credentials, qualifications and employer of the person(s) who performed or had any bearing on the adverse benefit determination and appeal requests; the name, credentials and qualifications of any consultant(s) and any and all documents and information provided by said consultant(s) relied upon by my health plan or health insurer for the adverse benefit determination and any subsequent determinations. This authorization includes the discovery of any and all relevant plan and other documents, data, policies, protocols

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

ASSIGNMENT OF BENEFITS (CONTINUED)

and other information relied upon and/or relevant to my pre or post-service claim for benefits. I understand that my Health Plan, TPA, Insurance Company or any third party involved in handling my claim for benefits is required to accept and honor this legally binding assignment of benefits in full compliance of all applicable governing laws. I understand to the full extent permissible under governing law that I have the right and authority to direct where benefit payment for claim submittals for services rendered is sent. I hereby instruct and direct my Health Plan or Health Insurance Issuer to pay all healthcare or plan benefits as entitled, directly to the healthcare provider submitting my claim for benefits. If my current policy or Plan prohibits direct payment to the medically related provider rendering services or prohibits any assignment of benefits or rights as authorized in this notice, I under all rights due me under governing laws, hereby instruct and direct my Plan or Health Insurance Issuer to provide specific Plan documentation marking such proof of non-assign ability clause to myself and my authorized representative. Such proof of non-assignability documentation must include written proof that the "non-assignability" is in full compliance of applicable federal law(s). Upon written proof that such "non-assignability" is supported by governing laws, I then instruct the insurer to make out the check to me and mail it directly to the healthcare Provider and address as listed on the claim submitted for benefits. I authorize the check to be deposited as payment towards the total charges for all healthcare services rendered. I understand that my insurance coverage is a contract between me and my insurance company, health plan or employer group and that I am responsible for all obligations under my plan including providing accurate information and assistance to ensure all benefits entitled under my plan or policy are paid in compliance with plan terms and governing laws. I acknowledge and understand that I may be eligible for any financial hardship, medically indigent or charity care practices program that the provider may have available.

I specifically request and authorize the State Insurance Department or any federal agency having oversight or enforcement authority or responsibilities over my governing Plan, group or health insurer related to entitled benefits and all protected rights, to perform as requested by my authorized representative or business associate as assigned by *Georgia Eye Physicians & Surgeons*, any compliance assistance, administrative reviews or investigations associated with handling of benefits, any appeal requests or other rights not satisfied by my Plan or health insurer. I request any state or federal agency as designated to work directly with my appointed representative as it relates to any request for compliance assistance, administrative review or investigation, wholly in my stead as applicable to all Plan, health insurer and fiduciary obligations. A photocopy of this Assignment shall be considered as effective and valid as the original. I understand this assignment will remain in effect until revoked by me in writing except (a) to the extent that the covered entity has already used or disclosed information under the authorization, or (b) if the authorization was obtained as a condition of obtaining insurance coverage for services rendered, other law that provides the insured or claimant with the right to contest a claim under the policy. I have read and fully understand the agreement.

Signature of Patient/Guarantor	Full Address (Required by Some Insurance Plans)	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 Medical 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 anytime.

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