Georgia Eye Institute
PATIENT REGISTRATION

DATE _____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____
MARITAL STATUS ☐ MARRIED ☐ SINGLE RACE _____
☐ DIVORCED ☐ WIDOWED
(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT
☐ OTHER _____
EMPLOYER _____
HOW DID YOU HEAR OF US? _____

HOME ADDRESS _____
_____
CITY _____ STATE _____ ZIP _____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
HOME PHONE (____) _____
WORK PHONE (____) _____
PRIMARY CARE PHYSICIAN _____
REFERRING PHYSICIAN _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
INSURED DATE OF BIRTH ____/____/____ INSURED SSN _____
POLICY # _____ GROUP # _____ PHONE (____) _____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
INSURED DATE OF BIRTH ____/____/____ INSURED SSN _____
POLICY # _____ GROUP # _____ PHONE (____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (____) _____
SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____ SEX _____ RELATIONSHIP TO PATIENT _____
FIRST NAME _____ MIDDLE _____ HOME PHONE (____) _____
LAST NAME _____ WORK PHONE (____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ RELATIONSHIP TO PATIENT _____
RELATIONSHIP _____ DATE OF BIRTH _____
FIRST NAME _____ MIDDLE _____ DAYTIME PHONE (____) _____
LAST NAME _____ EMPLOYER _____
ADDRESS _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

Georgia Eye Institute

Physician Practice Financial Policy and Release of Information

The following is a statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physician practice. We require you to read and sign this document prior to treatment by this facility.

Patient Responsibility

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy this practice will file your claim with your insurance carrier, however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Initial_____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial_____

When you receive a statement from the Georgia Eye Institute Physician Practice, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial_____

Authorization for Treatment and to Release Information

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for this Georgia Eye Institute Physician Practice to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payor representatives in order to process health care claims incurred at the office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

Initial_____

I understand that I am financially responsible to the Georgia Eye Institute Physician Practice for any balance not covered by the insurance carrier.

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid directly to this Georgia Eye Institute Physician Practice.

_____

Patient Name (please print)

_____ _____ _____

Signature of Patient or Responsible Party

Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been provided a copy of the Notice of Privacy Practices ("Notice") for the Georgia Eye Institute of the Southeast, LLC.

Federal regulation requires that we give our patients or their authorized representatives our Notice before he/she signs this acknowledgment.

PATIENTS PLEASE SIGN AND PRINT YOUR NAME BELOW

***Representative:** If you are signing for the patient, please sign and print your name*

X_____ _____

SIGNATURE OF PATIENT **Date**
Or Patient's Representative

X_____ _____

PRINTED NAME OF PATIENT **Relationship to Patient**
Or Patient's Representative ***(REPRESENTATIVE ONLY)***

STAFF ONLY

☐ Patient signed with no restrictions

☐ Patient signed with restrictions:_____

We attempted to obtain written acknowledgement of receipt of our Notice, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining

☐ Emergency situation prevented obtaining ☐ Other_____

_____ _____

Signature of Staff Member Date

GEORGIA EYE
INSTITUTE

PATIENT NAME:_____ DATE:_____

EMAIL:_____ DOB:_____

HEIGHT:_____ WEIGHT:_____

PLEASE CHECK OR CIRCLE ANY SYMPTOMS THAT ARE CHRONIC OR PERSISTENT

CONSTITUTIONAL
- ☐ FEVER / CHILLS
- ☐ LETHARGY / TIREDNESS
- ☐ WEIGHT LOSS / GAIN

OTHER_____

EYES
- ☐ BLURRING OF VISION
- ☐ DOUBLE VISION
- ☐ FLASHES / FLOATERS
- ☐ RED / IRRITATED / TEARING
- ☐ ITCHING

OTHER_____

EAR / NOSE / THROAT
- ☐ HEARING LOSS
- ☐ RINGING
- ☐ SINUSITIS

OTHER_____

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ IRREGULAR BEAT

OTHER_____

RESPIRATORY
- ☐ SHORTNESS OF BREATH
- ☐ COUGH

OTHER_____

LYMPHATIC
- ☐ BLEED / BRUISE EASILY
- ☐ SWOLLEN GLANDS

OTHER_____

GENITOURINARY
- ☐ BLOOD IN URINE

MUSCULOSKELETAL
- ☐ PAIN / SWELLING
- ☐ STIFFNESS

NEUROLOGIC
- ☐ NUMBNESS / TINGLING
- ☐ WEAKNESS IN ARM / LEG
- ☐ HEADACHE

OTHER_____

ENDOCRINE
- ☐ HEAT / COLD INTOLERANCE
- ☐ DRY SKIN

OTHER_____

INTEGUMENT / SKIN
- ☐ RASH
- ☐ SORES / ULCERS

OTHER_____

PSYCHIATRIC
- ☐ DEPRESSION

OTHER_____

GASTROINTESTINAL
- ☐ NAUSEA / VOMITING
- ☐ CONSTIPATION/ DIARRHEA
- ☐ STOMACH ULCERS

OTHER_____

ALLERGIES
- ☐ SEASONAL
- ☐ FOOD
- ☐ DRUG/ALLERGY:

_____
_____
_____
_____

see other side

MEDICAL PROBLEMS

- ☐ HYPERTENSION
- ☐ DIABETES/DURATION_____
- ☐ ANEMIA (LOW BLOOD)
- ☐ CANCER
- ☐ KIDNEY FAILURE
- ☐ STROKE
- ☐ HEART DISEASE
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ SICKLE CELL
- ☐ HIV

OTHER_____

FAMILY HISTORY

- ☐ RETINAL TEARS/DETACHMENTS
- ☐ GLAUCOMA
- ☐ SICKLE CELL DISEASE
- ☐ MACULAR DEGENERATION

SOCIAL HISTORY

- ☐ SMOKING__PACKS / DAY
- ☐ ALCOHOL

OCCUPATION:_____

MEDICATION(S)

_____

_____

_____

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_____

_____

PATIENT SIGNATURE:_____

OCULAR SURGERIES / DATE

_____

_____

_____

_____

OTHER SURGERIES / DATE

_____

_____

_____

REFERRING PHYSICIAN

_____

PRIMARY CARE PHYSICIAN

_____

GEORGIA EYE
INSTITUTE
Your vision. Our focus.

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. **It is an essential part of any eye examination and necessary to write a prescription for glasses or contact lenses.**

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations. Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for refraction is **$50.00** and this fee is collected at the time of service in addition to any co-payment or plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____
Patient Print Name

_____ _____
Patient Signature (Parent for Minor) Date

4720 Waters Avenue | Savannah, GA 31404
912.354.4800 | 912.629.5821
gaeyeinstitute.com

CONTACT LENS FITTING FEES

We want to thank you for considering a contact lens fitting with our doctors at Georgia Eye Institute of the Southeast, LLC and want you to understand the contact lens fitting process. If you have any questions, please do not hesitate to ask.

On the day of your examination, if needed and time permitting, a team member will instruct you on insertion and removal of the lenses. After receiving these instructions, you will wear the lenses for one to two weeks and return for a follow-up exam to evaluate the fit and prescription. If you are a previous wearer and no changes have been made to the fit, you will be free to purchase your prescribed lenses and will not need to go through the "trial" phase. Your fees will be determined by the physician and are **due at the time of the fitting** and are **non-refundable.** If you decide to "up-grade" to a different category (i.e., monovision to bifocals) after the initial visit, additional fees may be applied. Fees do not include the price of the contact lenses. A refraction may also be performed. There is a $50.00 refraction fee which is a separate charge and is not included in the below prices. Patients that have vision plans will also have a fitting fee and it may be paid out of pocket or taken from your allowance.

Fitting Fees are as follows:

Soft or gas perm: $35.00 - $65.00 • Renewal of contact lens fit and power (This re-validates your prescription for one year.)	**Soft Toric or Standard Gas Perm: $95.00 - $150.00** • First-time contact lens wearer • Change in brand or type of lens • Refit because of unknown contact lens specifications • Refit because of poor fit or poor visual acuity • Monovision
Soft: $65.00 - $115.00 • First-time contact lens wearer, • Change in brand or type of lens, • Refit because of unknown contact lens specifications, • Refit because of poor fit or poor visual acuity	**Specialty Contact Lenses: $200.00 - $300.00** • Gas perm toric • Soft or gas perm bifocal • Keratoconus • Post corneal surgery • Other corneal deformities

NOTICE:
Follow-up care is vital to determine the fit of the lens and to protect the health of your eyes. **If you elect to forego the follow-up care and return beyond the initial two month period, you may be charged a fee of $40.00.** You must have follow-up care in order to purchase contact lenses, unless otherwise authorized by the doctor. The price of lenses will vary depending on type and prescription. Contacts must be paid for in full at the time of dispensing. **Contact lens prescriptions are valid for one year, per Georgia and South Carolina state law.**

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered.

_____

Signature of Patient or Legal Guardian Date