GEORGIA OPHTHALMOLOGY ASSOCIATES,PC **PATIENT INFORMATION**

NAME: LAST FIRST MIDDLE INITIAL

HOME / CELL PHONE #:______________________________

WORK PHONE#:________________________________

MAILING ADDRESS:
APT #:

CITY/STATE: ZIP CODE: SOCIAL SECURITY #:

DATE OF BIRTH: MARITIAL STATUS: Circle ONE SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER:

EMAIL:

WHO REFERRED YOU TO US? Do you wear Contact Lenses or are you here today to get a Contact Lens prescription?
YES NO

REASON FOR TODAY'S VISIT: ____

Is this visit the result of an accident? YES NO

WAS THE ACCIDENT WORK RELATED? YES NO

WAS THE INJURY RELATED TO A CAR ACCIDENT? YES NO If you answered **"YES"** to any of these questions **–**

STOP! Please notify our front desk staff immediately as accident visits require prior authorization from the insurance company.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:

INSURANCE ADDRESS:

GROUP #: INSURANCE ID #:

POLICY HOLDERS NAME (IF NOT YOURSELF) POLICY HOLDER SS#: (IF NOT YOURSELF) DOB:

RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE COMPANY NAME:

INSURANCE ADDRESS:

GROUP #: INSURANCE ID #:

POLICY HOLDERS NAME (IF NOT YOURSELF) POLICY HOLDER SS# (IF NOT YOURSELF) DOB:

RELATIONSHIP TO PATIENT:

VISION INSURANCE

Medical insurance is different from *VISION* insurance.
If you have separate vision insurance, please complete the information below.

NAME OF VISION INSURANCE COMPANY:

POLICY HOLDERS NAME (IF NOT YOURSELF) : POLICY HOLDER SS# (IF NOT YOURSELF):

RELATIONSHIP TO PATIENT: DOB:

FINANCIAL INFORMATION

Person responsible for bill if "NOT" yourself

Name: DOB:

Address: City: State: Zip Code:

Relationship to patient: Phone number:

EMERGENCY CONTACT INFORMATION

Emergency Contact: Relationship to Patient: Phone #:

SIGNATURE OF PERSON COMPLETING FORM ____DATE________________ Rev 1/12

Georgia Ophthalmology Associates, PC

FINANCIAL POLICY

Payment in full is expected at the time services are rendered, including co-pays, deductibles, costs for items not covered by insurance and those patients without insurance coverage. Our office will accept most payment arrangements if the arrangements are made in advance, including a down payment and signed agreement. Financing is available (in advance) for any surgical services through Chase Health Advance or Care Credit.

Our practice will file your claim for services in a timely manner with information provided by you.

PATIENT RESPONSIBILITY

It is YOUR responsibility to:

- Contact your insurance company to obtain co-pay, coinsurance/deductible information and verify that our physicians are participating with your insurance and IN-NETWORK.
- Provide our practice with correct and current insurance information on or before the date of service.
- Read and understand your own insurance policy.
- Obtain your own insurance referrals.

We will bill you *DIRECTLY FOR ALL CHARGES* related to your office visit:

- If the insurance information provided was not current or incorrect.
- If a prior authorization or referral was not obtained.
- If your insurance company requested additional information from you and you have not provided it to them.
- If your insurance coverage was not in effect on the date of service.
- If your insurance company denies any service as "not medically necessary" or "not covered".
- If your insurance company denies any of our charges, including Contact Lens fittings and Refractions.
- **A $50 administrative fee will be added to your account in the event the account is turned over to a collection agency.**
- **A $30 NSF returned check fee will be added to your account if a check received for payment is returned by your bank.**

SIGNATURE PAGE

HIPAA

I was provided an opportunity to read (and receive a copy if requested) the Georgia Ophthalmology Associates, PC & Aspects Optical Notice of Privacy Practices. In accordance with HIPAA, your medical records will be shared with your insurance company and any other entity covered under T.P.O. (treatment, payment, health care operations). If you wish to have us share your records with any other physician or entities, you will be required to complete a HIPAA Medical Release of records.

____

Signature (or Parent/Guardian)

____

Printed Name

SIGNATURE ON FILE AUTHORIZATION

Patients who have insurance will become "Self Pay" patients if for any reason their insurance does not pay our claim for services.

Self Pay: I understand that payment is my responsibility and expected in full at time of service.

Workers' Compensation or Auto Insurance Patients: I understand that I am responsible for all charges not paid by my workers' compensation or an auto insurance company.

Private Insurance and/or Medicare Insurance Beneficiaries: I authorize this physician to release any information in the course of my exam or treatment and permit payment directly to this office. I recognize and accept responsibility for any balance or fee not covered, as per my health insurance contract.

I certify that the information provided by me to be true and correct. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Georgia Ophthalmology Associates, PC, Stephen P. Leff, M.D. or Gayle Leff Goldstein, M.D. or any other physician employed by GAOA and payment should be sent directly to their office.

I have read, understand, and agree to the information provided above. I have provided correct and current insurance information to the best of my knowledge.

_____________________________   __________________________________

Printed Name   Social Security # of Responsible Party

_____________________________________   _____________________

Signature of Patient or *Responsible Party   DATE

***Relationship to Patient:** Mother / Father Grandparent Care Giver Other___________

Your signature and acknowledgment of our Financial Policy will remain in effect until you revoke in writing. To revoke, mail your request to: GAOA, 465 Winn Way, Suite 140, Decatur, GA 30030. Rev. 01/01/2012

GEORGIA OPHTHALMOLOGY ASSOCIATES, PC **MEDICAL HISTORY QUESTIONNAIRE**

NAME____ **DOB** _______________ Date ____________________

Pharmacy Name __________________________________ Telephone #: ________________________

List any **medication** you currently take (RX and over-the-counter) –OR- **PROVIDE A LIST OF MEDS for us to copy**:

____

Do you have **allergies** to any medications? NO YES → ____

List any **surgeries** you have had (cataract, appendectomy) since your last visit with us:

____

Are you currently receiving cancer treatments? YES NO

REASON FOR TODAY'S VISIT ____

Is this visit the result of an accident? YES NO

WAS THE ACCIDENT WORK RELATED? YES NO

WAS THE INJURY RELATED TO A CAR ACCIDENT? YES NO

If you answered "YES" to any accident questions -- **STOP !** - Notify our front desk staff immediately as accident visits require prior authorization from the insurance companies.

ARE YOU HERE TODAY TO RECEIVE A NEW GLASSES PRESCRIPTION? YES NO

DO YOU WEAR CONTACT LENSES? YES NO

Do you *currently* have any problems in the following areas?

	YES	**NO**	**IF YES, please provide additional information.**
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse)			
RESPIRATORY (congestion, wheezing, short of breath)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES - Are you pregnant? Nursing ?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases? (circle all that apply)

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

List any other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living? (driving, reading, sports, work, hobbies, etc.) YES NO

Have you ever had a blood transfusion?...........YES NO

Do you drink alcohol?.................YES NO IF YES, how much? _____________

Do you smoke?..........................YES NO IF YES, how much?______________ How many years? ___________