Georgia Ophthalmology Associates, PC

465 Winn Way, Suite 140, Decatur, GA 30030
1700 Tree Lane Rd, Suite 135, Snellville, GA 30078 Main Office number: (404) 298-5557

PATIENT INFORMATION

NAME (Last, First, Middle)	Jr / Sr.	SS#	BIRTH DATE	LANGUAGE	Sex

LOCAL ADDRESS	CITY, STATE, ZIP	REFERRING PHYSICIAN	PHONE NUMBER

HOME PHONE	DAY PHONE	*EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS:		SMOKER (Y / N)?	VETERAN (Y / N)?	Emergency Contact Name	Contact Phone	Home Phone

RACE:	ETHNICITY:	PREFERRED LANGUAGE:
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if applicable)
ADDRESS		ADDRESS
CITY, STATE ZIP		CITY, STATE ZIP
WORK PHONE		WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

Name (Last, First Middle)	SS#	Birth date	Language	Sex

Local Address	City, State Zip	Secondary Billing Address

Home Phone	Day Phone	Email Address	City, State Zip

Marital Status	Student Status	Smoker Y / N ?	Veteran Y / N ?	Primary Care Provider	Home phone

Relationship to Patient	

PRIMARY INSURANCE

Name of Insurance Company	Policy #	
Address of Insurance Co	Group #	
Relationship to Patient	Effective Date	Expiration Date

SECONDARY INSURANCE

Name and Address of Insurance Company	Policy #
Relationship to Patient	Group #

VISION PLAN

Name of Vision Plan	Policy #	
Relationship to Patient	Effective Date	Expiration Date

E-PRESCRIBE CONSENT: With my signature below, I consent for GAOA to obtain my medication prescription history and place my new prescription order through the electronic prescribing system used by Georgia Ophthalmology Associates.

***EMAIL DISCLOSURE**: If you have provided your email address, we will only use this information at our practice to provide patients with information regarding new treatments available, advise you of discounts and offers from our practice and providers, discuss appointments.

AUTHORIZATION OF PAYMENT: I certify that the information above, provided by me, is true and correct. I request that payment of authorized benefits be made on my behalf. I understand I am responsible for all contractual charges not paid by my insurance.

Patient's Signature____ **Date** ______________

Rev 4/2014

Notice of Privacy Practices

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, technicians, physicians and other member of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administrative records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give our health information without your permission for the following purposes:

Required by Law

We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funerals directors and organ donor agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: if you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

If any other situation arises, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorizations to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact that person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information.

We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

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Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protecting health information, and to abide by the terms of the Notice currently in effect.

Changes In Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact our Privacy Office listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address, upon request. You will not be penalized in any way for filing a complaint.

Contact person

For any questions, requests or complaints, please contact:

Gayle Leff Goldstein, M.D. – Privacy Officer
Georgia Ophthalmology Associates, PC
465 Winn Way, Suite 140
Decatur, GA 30030
(404) 298-5557
decatur@gaoa.com

Effective August 29, 2014

Georgia Ophthalmology Associates, PC

Stephen P. Leff, M.D.
Gayle Leff Goldstein, M.D.
Stephanie Sailor, O.D.

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 Care Credit.

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

You will have a vision exam and a **REFRACTION**. The refraction determines your current corrected vision and also provides information about what glasses prescription you may need. This is a separate billable service from your exam. You should contact your insurance carrier to inquire whether refractions are covered by your plan. We will collect the fee for this service at check in. Most insurance plans do not cover the cost. Some may partially cover the cost of a refraction fee.**(Medicare does not cover refraction costs).**

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.

ADDITIONAL CHARGES FOR NEGLECTING YOUR FINANCIAL RESPONSIBILTIES:

- **A $30 returned check fee will be added to your account if a check received for payment is returned by your bank for any reason. We do not re-deposit checks. We do not accept post dated checks under any circumstances.**
- **A $50 administrative fee will be added to your account in the event the account is turned over to a collection agency.**

PLEASE Read AND Sign SIGNATURE PAGE

Please read Financial Policy ***before*** you sign below.

HIPAA RELEASE OF MEDICAL INFORMATION:
By my signature below, I would like ALL RECORDS generated from Georgia Ophthalmology Associates (GAOA) shared with the following person(s), this will also include in face-to-face discussions, telephone conversations and written correspondence. This release will remain in effect until revoked by me in writing, see below. ***(Please print):***

Name________________________________ Relationship _________________
Name________________________________ Relationship_________________
Name________________________________ Relationship_________________

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 for each.

Financial Responsibilities, Signature on File Authorization, HIPAA Authorization, And E-Prescribe Consent:
By my signature below, I acknowledge that I have read the reverse side and understand additional charges that could be incurred as a result of neglecting by financial responsibilities.
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, including fees necessary to collect the unpaid balance.
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 GAOA. Payment should be sent directly to GAOA offices. 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.

HIPAA Consent & E-Prescribe Consent: By my signature below, I acknowledge receipt of HIPAA Notice of Privacy Practices and give my consent to share my PHI under T, P, O. I further consent for GAOA to obtain my medication prescription history and place my prescription order through the electronic prescribing system used by GAOA.

Signature of Patient or *Responsible Party **Date**

_________________________________ _________________________________
Printed Name Social Security # of Responsible Party

***Relationship to Patient:** Parent / Grandparent / P.O.A. / Care Giver Other_________________
Your signature and acknowledgment 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 08/2014**

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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, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, 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? _________