VISION Eye Group
4050 Riverside Drive
Macon, GA 31210
Phone: (478) 744-1710
Fax:(478) 259-4503

You have an upcoming appointment with one of our physicians. As a new patient we would like to provide you with some information you will need to know before your visit.

If your appointment is for a cataract evaluation,
please do not wear any contact lenses 2 weeks prior to your examination.

The average length of time for an appointment is one to one and half hours. Times can vary depending on dilation and testing. In order to keep your visit within this range, please complete the enclosed patient paperwork and bring it with you at the time of your appointment.

Due to the ever-increasing cost of billing procedures, and in an effort to keep from raising our fees, all copays and payments are due the day services are rendered. All payments for materials, including glasses and contacts, must be paid in full on the date ordered.

If you are a participant in a medical insurance plan whereby, we are listed as providers, we will be glad to file your insurance for you. If you do not have your insurance card with you at the time of your visit, we will have to reschedule your appointment for another day.

SO, PLEASE BRING YOUR INSURANCE CARDS (MEDICAL AND VISION)

AS WELL AS A PHOTO ID WITH YOU.

As we are Medicare, participating physicians, we will file all Medicare. Patients are responsible for 20% of Medicare's allowable charges, any deductions not satisfied, and all non-covered services.

REFRACTION FEE
CPT CODE 92015
$40.00

This is a part of the eye exam that is for the purpose of prescribing, fitting, or changing glasses.

Since all insurance carriers, including Medicare, consider this routine, it is not a covered expense.

Therefore, it is the patient's responsibility.

Please check your insurance policy before your visit to make sure what coverage is.

If you have any further questions, please feel free to contact us at 478-744-1710

VISION
Eye Group

Retinal Imaging is a valuable part of a comprehensive eye exam. This important feature allows our doctors to better evaluate the back of the eye as well as discuss and show the images with you during the exam. Additionally, it provides a baseline image and allows for future comparison. **Some insurances will cover but if not, there is a $39.00 charge for this service.**

_____ _____

Patient Name (Printed) Date of Birth

I would like retinal imaging performed on today's visit:

_____

Patient (or person authorized to sign patient) Date

I **decline** retinal imaging on today's visit:

_____

Patient (or person authorized to sign patient) Date

PATIENT INFORMATION

PATIENT

NAME: _____DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

SOCIAL SECURITY #: _____

SEX: M ☐ F ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

EMAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYED BY: _____

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ *PHONE #: (_____)* _____-_____

If Patient is a Minor

PARENT NAME: _____ DATE OF BIRTH: _____/_____/_____

PARENT SOCIAL SECURITY #: _____

GUARANTOR

PRIMARY INSURANCE: _____ ID: _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: SELF ☐ SPOUSE ☐ CHILD ☐

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE: _____ ID: _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: SELF ☐ SPOUSE ☐ CHILD ☐

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____/_____/_____

Patient Name: _____ Date of Birth: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration of its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this Authorization to be used in place of the original, and request payment of Medical Insurance Benefits either to myself or to the part who accepts assignment. Regulations pertaining to Medicare Assignment or Benefits apply. I also request that payment under the Medical Insurance Program be made either to me or to Vision Eye Group on any bills for services furnished to me by that group. I understand that I am financially responsible to the physician for charges not covered by this assignment. A copy of this authorization shall be valid as the original.

_____

Patient (or person authorized to sign patient) Date

DILATION CONSENT

Dilating drops are used to dilate or enlarge the pupils of the eye allowing our physicians to get a better view of the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. Because driving may be difficult after an examination, it's best if you make arrangements not to drive yourself.

If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Vision Eye Group to administer dilating eye drops.

_____

Patient (or person authorized to sign patient) Date

WRITTEN ACKNOWLEDGMENT FORM

I hereby acknowledge receipt of Vision Eye Group's Notice of Privacy Practices.

_____

Patient (or person authorized to sign patient) Date

-OR-

For Minor (Parent or Legal Guardian)

I am a parent or legal guardian of _____(Patient Name). I hereby acknowledge receipt of Vision Eye Group's Notice of Privacy Practices with respect to the patient.

_____

Patient (or person authorized to sign patient) Date

Relationship to Patient: ___Parent ___Legal Guardian

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordination, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- This practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fund-raising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fund-raising communications from us.

The following use and disclosures of PHI will only be made pursuant to use receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsided treatment and healthcare operations
- Disclosures that constitute a sale of PHI under HIPPA
- Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosure of family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI
- The right to amend your PHI
- The right to receive an accounting of disclosures of your PHI
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to your PHI.

This notice is effective as of April 19, 2019 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You may recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Constitutional Systems
Fever ☐Yes ☐ No
Fatigue ☐Yes ☐ No
Weight loss ☐Yes ☐ No
Other _____

Ear, Nose, Mouth, Throat
Hearing Loss ☐Yes ☐ No
Sinus Congestion/Disorders ☐Yes ☐ No
Dry Throat/Mouth ☐Yes ☐ No
Other _____

Cardiovascular
Atrial Fibrillation ☐Yes ☐ No
Heart Disease ☐Yes ☐ No
Hypertension (high blood pressure) ☐Yes ☐ No
High Cholesterol ☐Yes ☐ No
Heart Attack ☐Yes ☐ No
Stroke/TIA ☐Yes ☐ No
Other _____

Respiratory
Asthma ☐Yes ☐ No
Emphysema or COPD (circle one) ☐Yes ☐ No
Shortness of Breath ☐Yes ☐ No
Sleep Apnea ☐Yes ☐ No
Snoring ☐Yes ☐ No
COVID-19 ☐Yes ☐ No

Gastrointestinal
Crohn's ☐Yes ☐ No
Irritable Bowel Syndrome ☐Yes ☐ No
Stomach/Intestinal ☐Yes ☐ No
Other _____

Genitourinary
Bladder ☐Yes ☐ No
Kidney Disease ☐Yes ☐ No
Prostate Enlargement/Disorder ☐Yes ☐ No
STDs ☐Yes ☐ No
Other _____

Hematological/Lymphatic
Anemia ☐Yes ☐ No
Sickle Cell or Trait ☐Yes ☐ No
Swelling ☐Yes ☐ No
Other _____

Musculoskeletal
Arthritis ☐Yes ☐ No
(circle one) osteo, rheumatoid or psoriatic
Muscle/Joint/Back Pain ☐Yes ☐ No
Other _____

Integumentary
Rosacea ☐Yes ☐ No
Shingles ☐Yes ☐ No
Skin Cancer ☐Yes ☐ No
Other _____

Neurological
Multiple Sclerosis ☐Yes ☐ No
Convulsions/Seizures ☐Yes ☐ No
Frequent Headaches ☐Yes ☐ No
Restless Leg Syndrome ☐Yes ☐ No
Head Injury ☐Yes ☐ No
Other _____

Allergic/Immunologic
Seasonal Allergies ☐Yes ☐ No
Lupus ☐Yes ☐ No
Sarcoidosis ☐Yes ☐ No
HIV/AIDS ☐Yes ☐ No
Other _____

Psychiatric
Memory Loss ☐Yes ☐ No
Depression ☐Yes ☐ No
Anxiety ☐Yes ☐ No
Other _____

Endocrine
Diabetes ☐Yes ☐ No
(circle one) Type I or II
Thyroid ☐Yes ☐ No
(circle one) Hypothyroid or Hyperthyroid
Pituitary ☐Yes ☐ No
Other _____

Cancer
Cancer ☐Yes ☐ No
Please Specify Type: _____

Maternity
Pregnant or Nursing ☐Yes ☐ No

Eye Diseases/History

Amblyopia (lazy eye)	☐Yes	☐ No	Dry Eye Syndrome	☐Yes	☐ No
Blindness	☐Yes	☐ No	Eye/Lid Injury	☐Yes	☐ No
Cataract	☐Yes	☐ No	Glaucoma	☐Yes	☐ No
Color Blindness	☐Yes	☐ No	Macular Degeneration	☐Yes	☐ No
Diabetic Retinopathy	☐Yes	☐ No	Retinal Detachment	☐Yes	☐ No
Strabismus (eye alignment)	☐Yes	☐ No	Other _____		

EYE SURGERY/TRAUMA: _____

_____

Do you currently use any eye drops? If yes, please list: _____

_____

_____

Do you wear: Glasses? ☐Yes ☐ No If **YES**, how old is your present pair of lenses? _____

Contact lenses? ☐Yes ☐ No If **YES**, do you over wear or sleep in your lenses? ☐Yes ☐ No

Current Eye Symptoms

Loss of Central Vision	☐Yes	☐ No	Mucous Discharge	☐Yes	☐ No	Eye Pain or Soreness	☐Yes	☐ No
Blurred Vision	☐Yes	☐ No	Redness	☐Yes	☐ No	Itching	☐Yes	☐ No
Burning	☐Yes	☐ No	Double Vision	☐Yes	☐ No	Dryness	☐Yes	☐ No
Distorted Vision (halos)	☐Yes	☐ No	Flashes/Floaters	☐Yes	☐ No	Glare/Light Sensitivity	☐Yes	☐ No
Loss of Side Vision	☐Yes	☐ No	Excess Tearing	☐Yes	☐ No	Other _____		
Chronic Infection of Eye/Lid	☐Yes	☐ No	Sandy/Gritty Feeling	☐Yes	☐ No	_____		

Social History

Job (Occupation) ☐Yes ☐ No

Do You Drive? ☐Yes ☐ No

Have you had the Pneumococcal (Pneumonia) Vaccine?

☐Yes ☐ No

If YES, WHEN? _____

Tobacco Use? ☐Yes ☐ No

If YES, How Much? _____

(Includes Smoking, Chew, Vape)

Do You Drink Alcohol? ☐Yes ☐ No

If YES, How Much? _____

Do You Use Recreational Drugs? ☐Yes ☐ No

List any Surgeries and/or hospitalizations:

_____

_____

_____

_____

Family History:

Do any medical or eye diseases run in your family (**blood-related**)?
If YES, please note relationship.

☐Glaucoma _____ ☐Cataracts, early onset _____

☐Diabetes _____ ☐ Heart Disease _____

☐High Blood Pressure: _____ ☐Blindness _____

☐Macular Degeneration: _____ ☐Other: _____

Medication Reconciliation

Patient Name: _____ DOB: _____ PH #: _____

Pharmacy (Name/Address): _____

Primary Care Physician (Name/Address): _____

Please list any medications you take, including vitamins and supplements:

Medication	Dosage	How Often	Last Dose (Office Use Only)

Please list any allergies you have:

Allergy	Reaction

Patient Signature: _____ **Date:** _____

Physician Signature: _____ *(For Surgery Center Use Only)* **Date:** _____

Updated: _____
(Patient Initials) (Date) (Time)

Patient Label

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AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I request that Vision Eye Group communicate with me, or the designated individual(s) identified below, concerning my medical information, including billing. This authorization will remain valid for one year from the date signed. I understand I have the right to revoke this authorization at any time.

_____ _____
Patient's Name (Printed) **Date of Birth**

RELEASED TO: (Please list any family members, friends, or physicians we can talk to on your behalf)

_____ _____ _____
Name Telephone Relationship

_____ _____ _____
Name Telephone Relationship

_____ _____ _____
Name Telephone Relationship

_____ _____ _____
Name Telephone Relationship

HEALTH CARE SURROGACY

Is there a person that is authorized to make health care decisions on your behalf if you are unable?

☐ Yes. If yes, please list authorized person: _____

☐ No.

_____ _____
Patient Signature Date