



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

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 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 references 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 subsidized 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.



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.

This consent will remain valid for one year from the date signed.

Patient Name (Printed)

Date of Birth

Yes, I would like retinal imaging performed:

Patient (or person authorized to sign patient)

Date

OR

No, I **decline** retinal imaging:

Patient (or person authorized to sign patient)

Date



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 in effect for 3 years or until permissions are revoked.** 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

This form must be signed to be valid.

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 #: (____) _____ - _____

RESPONSIBLE PARTY

If Patient is a Minor (Under 18)

PARENT/GUARDIAN NAME: _____

DATE OF BIRTH: ____/____/____

PARENT SOCIAL SECURITY #: _____

MAILING ADDRESS (if different from above):

CITY: _____ STATE: _____ ZIP: _____

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 for 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

E-PRESCRIBING / MEDICATION HISTORY CONSENT FORM

The providers at Vision Eye Group use an electronic medical record system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection which improves the accuracy and timely transmission of your medical information. E-Prescribing greatly reduces medication errors and enhances patient safety.

There are several standards that must be included in an e-prescription program.

These include:

1. Formulary and benefit transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan.
2. Medication history transaction: Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.
3. Fill status notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up or partially filled.

My signature certifies that I have read and understood the scope of my consent and that I authorize the access of my medication history.

Patient (or person authorized to sign patient) Date

PATIENT MEDICAL HISTORY (Mark if you have either currently or have had in the past)

Patient Name: _____ **Date of Birth:** _____

<p><u>Constitutional Systems</u></p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Musculoskeletal</u></p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No (circle one) osteo, rheumatoid or psoriatic</p> <p>Muscle/Joint/Back Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Ear, Nose, Mouth, Throat</u></p> <p>Hearing Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Congestion/Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Throat/Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Integumentary</u></p> <p>Rosacea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Cardiovascular</u></p> <p>Atrial Fibrillation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypertension (high blood pressure) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke/TIA <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Neurological</u></p> <p>Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Convulsions/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Restless Leg Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Respiratory</u></p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema or COPD (circle one) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>COVID-19 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Allergic/Immunologic</u></p> <p>Seasonal Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sarcoidosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Gastrointestinal</u></p> <p>Crohn's <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irritable Bowel Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach/Intestinal <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Psychiatric</u></p> <p>Memory Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Genitourinary</u></p> <p>Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prostate Enlargement/Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>STDs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Endocrine</u></p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No (circle one) Type I or II</p> <p>Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No (circle one) Hypothyroid or Hyperthyroid</p> <p>Pituitary <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>
<p><u>Hematological/Lymphatic</u></p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sickle Cell or Trait <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p>	<p><u>Cancer</u></p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Please Specify Type: _____</p> <hr/> <p><u>Maternity</u></p> <p>Pregnant or Nursing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Eye Diseases/History

Amblyopia (lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eye Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye/Lid Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetic Retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strabismus (eye alignment)	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mucous Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain or Soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Distorted Vision (halos)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flashes/Floaters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glare/Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Side Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excess Tearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Chronic Infection of Eye/Lid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy/Gritty Feeling	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Cataracts, early onset _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> High Blood Pressure: _____	<input type="checkbox"/> Blindness _____
<input type="checkbox"/> Macular Degeneration: _____	<input type="checkbox"/> Other: _____

Cataract Evaluation Patients Only: General Functioning Vision Questionnaire

Patient Name: _____ Date of Birth: _____

1. Do you have any difficulty, even with glasses, reading small print, such as: labels on medicine bottles, a telephone book, food labels?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

2. Do you have any difficulty, even with glasses, reading a newspaper or a book?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

3. Do you have any difficulty, even with glasses, reading a large-print book or large-print newspaper or numbers on a telephone?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

4. Do you have any difficulty, even with glasses, recognizing people when they are close to you?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

5. Do you have any difficulty, even with glasses, seeing steps, stairs, or curbs?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

6. Do you have any difficulty, even with glasses, reading traffic signs, street signs, or store signs?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

7. Do you have any difficulty, even with glasses, doing fine handwork like sewing, knitting, crocheting, carpentry?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

8. Do you have any difficulty, even with glasses, writing checks or filling out forms?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

9. Do you have any difficulty, even with glasses, playing games such as bingo, dominos, card games, mahjong?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

10. Do you have any difficulty, even with glasses, taking part in sports like bowling, handball, tennis, or golf?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

11. Do you have any difficulty, even with glasses, cooking?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

12. Do you have any difficulty, even with glasses, watching television?

YES NO Not Applicable

If yes, how much difficulty do you currently have? A Little A Moderate Amount A Great Deal

13. Do you currently drive a car?

YES (Continue to Question 14) NO (Continue to Question 16 – skip 14 & 15)

14. How much difficulty do you have driving during the day because of your vision?

None A Little A Moderate Amount A Great Deal

15. How much difficulty do you have driving at night due to glares around lights?

None A Little A Moderate Amount A Great Deal

16. Have you ever driven a car?

YES, in the past (Continue to Question 17) NO, never (Skip Questions 17 & 18)

17. If you have driven in the past, when did you stop driving?

Less than 6 Months Ago 6-12 Months Ago More Than 12 Months Ago

18. If you have stopped driving, why did you stop driving?

Vision Other Illness Other: _____