DOUGLASVILLE
Eye Clinic

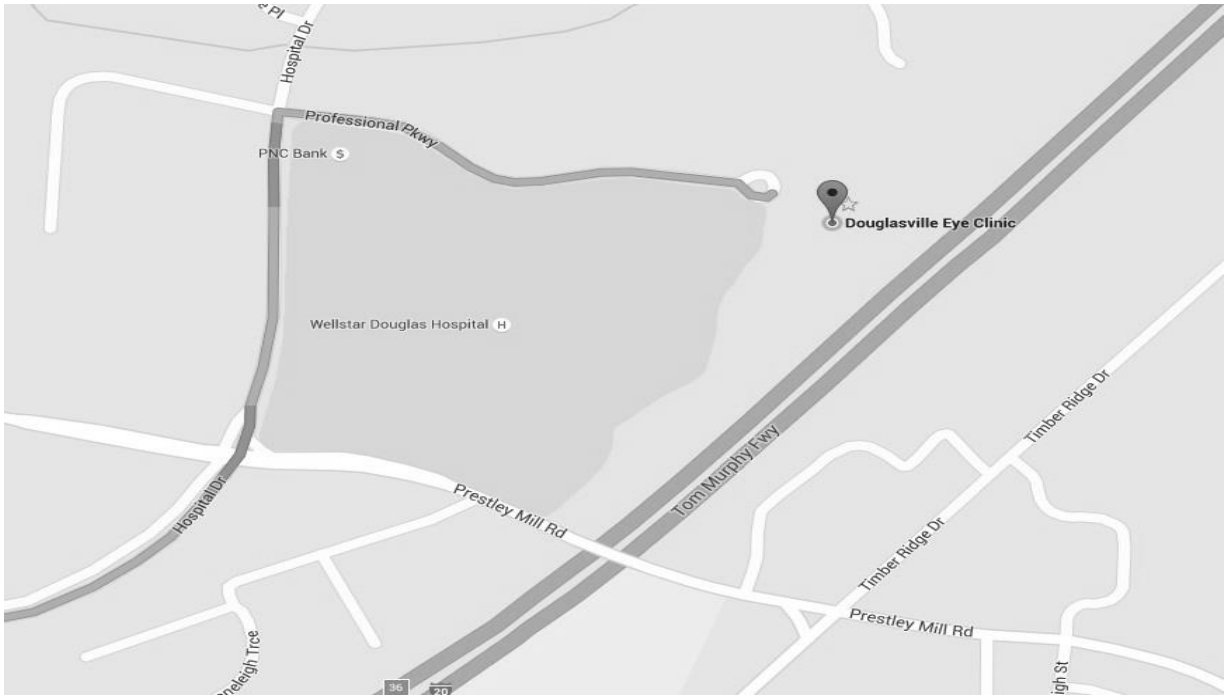
PLEASE COMPLETE ALL OF THE ENCLOSED FORMS AND BRING THEM WITH YOU AT THE TIME OF YOUR APPOINTMENT. FAILURE TO DO SO WILL DELAY YOUR APPOINTMENT.

Cancellations require 24 business hours' notice. Appointments not kept or cancelled prior to 24 hours will be assessed a $30.00 no show fee.

PLEASE BRING THE FOLLOWING ITEMS WITH YOU AND PRESENT AT TIME OF CHECK-IN

- Completed paperwork
- Insurance cards (Medical and Vision)
- Picture ID
- List of all MEDICATIONS you take with strengths and dosages
- Contact Lens wearers bring written prescription or boxes they came in
- Primary Care Physician's name and telephone
- Preferred pharmacy and telephone

NEW PATIENT COMPLETE EYE EXAM WILL TAKE 1-2 HOURS -YOUR EYES WILL BE DILATED



Turn onto Professional Parkway from Hospital Drive – (This is the only stop light between the hospital and the courthouse.) Go to the end of the street, the 6001 Professional Building is on the right.

6001 PROFESSIONAL PARKWAY SUITE 2040 DOUGLASVILLE, GA 30134 678-838-9999

WELCOME TO DOUGLASVILLE EYE CLINIC, P.C.

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION: Preferred Name: _____

LEGAL NAME: First _____ M.I._____ Last_____

SEX: ☐Male ☐Female MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

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

ETHNICITY: ☐Non-Hispanic/Latino ☐Mexican ☐Puerto Rican ☐Cuban ☐Other Hispanic/Latino

RACE: ☐White ☐Black/African American ☐Hispanic/Latino ☐Asian ☐American Indian/Alaskan Native

☐Native Hawaiian/Other Pacific Islander ☐DECLINE TO ANSWER

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____

ADDRESS: _____CITY: _____ STATE: _____ZIP: _____

PRIMARY PHONE: _____ CELL: _____ HOME: _____

E-MAIL ADDRESS: _____ OCCUPATION: _____

EMERGENCY CONTACT NAME: _____PHONE: _____

PRIMARY MEDICAL INSURANCE NAME: _____

MEMBER #: _____ GROUP #: _____

POLICY HOLDER RELATIONSHIP TO THE PATIENT: ☐SELF ☐ SPOUSE ☐CHILD ☐OTHER: _____

SECONDARY MEDICAL INSURANCE NAME: _____

MEMBER #: _____ GROUP #: _____

POLICY HOLDER RELATIONSHIP TO THE PATIENT: ☐SELF ☐ SPOUSE ☐CHILD ☐OTHER: _____

VISION INSURANCE NAME: _____

MEMBER #: _____ GROUP #: _____

POLICY HOLDER RELATIONSHIP TO THE PATIENT: ☐SELF ☐ SPOUSE ☐CHILD ☐OTHER: _____

FINANCIAL INFORMATION – PERSON RESPONSIBLE FOR THE BILL**:**

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

DOUGLASVILLE EYE CLINIC MEDICAL HISTORY RECORD

Patient Name: _____ Date of Birth: _____

Medical Doctors name: _____ **Referring** Doctors name: _____

Preferred Pharmacy: _____ Location/Phone#: _____

Are you **allergic** to any **medication**? ☐ **NONE KNOWN** ☐ YES, Please list

_____ _____ _____

Are you allergic to **LATEX**? ☐ Yes ☐ No

Do you currently **take ANY** prescription or over the counter **medication**?

☐ **NO** ☐ YES, **PLEASE LIST HERE OR PROVIDE A LIST OF ALL MEDICATIONS INCLUDING STRENGTH AND DOSAGE.**

_____ _____ _____

Have you ever taken **FLOMAX** or any other prostate medication? ☐ Yes ☐ No DISCONTINUED DATE _____

List any **EYE DROPS** you are currently using and how often: ☐ **NONE** ☐ Artificial Tears

_____ _____ _____

Do you have any **past or present** problems in the following areas, please **CIRCLE** Yes or No: **IF "YES" PLEASE EXPLAIN.**

☐ Yes ☐ No	General problems	_____
☐ Yes ☐ No	Ears, Nose, Throat, Mouth	_____
☐ Yes ☐ No	Lungs/Breathing	_____
☐ Yes ☐ No	Heart/Blood Vessels/Blood pressure/Cholesterol	_____
☐ Yes ☐ No	Skin/Hair	_____
☐ Yes ☐ No	Stomach/Intestines	_____
☐ Yes ☐ No	Prostate/Kidney/Bladder	_____
☐ Yes ☐ No	Endocrine/Diabetes/Thyroid/Hormones/Graves	_____
☐ Yes ☐ No	Neurological/Brain/Nerves	_____
☐ Yes ☐ No	Psychiatric/Anxiety/Depression	_____
☐ Yes ☐ No	Hematologic/Blood/Lymph	_____
☐ Yes ☐ No	Musculoskeletal/Joints	_____
☐ Yes ☐ No	Allergic/Immune Disorder/HIV/AIDS	_____
☐ Yes ☐ No	Cancer If "yes" what type? _____ DATE: _____	
	Currently undergoing treatment? Yes ☐ No ☐	

Social History:

☐ Yes ☐ No Tobacco Use: If yes, pack(s)/day_____ for _____ years. DISCONTINUED DATE _____

☐ Yes ☐ No Alcohol Use: If yes, how much _____ how often_____ for _____ years.
DISCONTINUED DATE _____

Past and/or present EYE problems including EYE surgeries: _____

_____

Surgical History: List **ANY** other surgeries you have ever had or check none: **NONE** ☐

_____

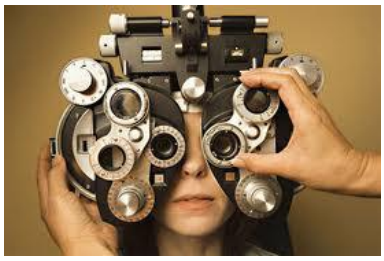
Family History:

	RELATIONSHIP		RELATIONSHIP
☐ Yes ☐ No Glaucoma	_____	☐ Yes ☐ No Macular Degeneration	_____
☐ Yes ☐ No Diabetes	_____	☐ Yes ☐ No Retinal Disease	_____

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

DOUGLASVILLE EYE CLINIC, P.C.
REFRACTION AND CONTACT LENS AGREEMENT



Refraction (checking for eyeglass prescription change) may be performed for the purpose of giving the patient a new eyeglass prescription or as a diagnostic test to help understand why a patient's visual acuity might be decreased.

Douglasville Eye Clinic has advised me that the refraction (checking for eyeglass prescription) is usually not covered by my MEDICAL insurance. It may be covered by some vision plans or if I carry vision benefits under my medical insurance plan.

It is the patient's responsibility to notify Douglasville Eye Clinic as to what their vision plan is and to verify that our physicians are participating in their insurance prior to their appointment.

I UNDERSTAND THAT IF I CHOOSE NOT TO HAVE REFRACTION I WILL NOT RECEIVE A GLASSES PRESCRIPTION.

I agree to pay for refraction at the time of service and if my medical insurance does pay Douglasville Eye Clinic for this service, I will be reimbursed by Douglasville Eye Clinic in a timely matter.

CPT	DESCRIPTION	CHARGE
92015	Refraction	$35.00

CONTACT LENS FITTING PRICE RANGE

We provide services for fitting MOST types of contact lenses. However, there is an additional fee for these services. Many times insurance will NOT cover this fee as it is not part of a routine eye exam.

REFIT-CURRENTLY WEARING CONTACT LENSES	$40.00-$100.00
NEW FIT-NEVER WORN CONTACT LENSES	$110.00-$135.00

This fee will be required annually as Georgia State Law mandates contact lens prescriptions are valid for 12 months. The fitting fee does not include the cost of any lenses. Exact fitting fee is determined by one of our licensed opticians.

IF YOU ARE CURRENTLY WEARING CONTACT LENSES, BRING EITHER YOUR MOST RECENT CONTACT LENS PRESCRIPTION OR CONTACT LENS CONTAINERS. **WITHOUT BRAND NAME, POWER, DIAMETER AND BASE CURVE, A RE FIT WILL BE REQUIRED.**

It is important that patients keep their follow-up appointments for contact lens evaluations. Failure to keep these appointments can result in additional fees after 30 days.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

DOUGLASVILLE EYE CLINIC, P.C.

FINANCIAL AND PRIVACY POLICIES DISCLOSURE

FORM FINANCIAL AGREEMENT AND HIPAA INFORMATION:

- **We require 24 hour cancellation notice. Appointments not kept and not cancelled within 24 business hours of the appointment time will be assessed a $30.00 no show fee.**
- Payment is expected at the time of the visit for any amounts due. This includes but is not limited to co-payments, deductibles and non-covered charges.
- Complete MEDICAL and VISION coverage must be provided prior to services.
  -A claim for services will be filed immediately upon completion of services on the information provided. We only accept vision plans requiring prior authorizations when notified of the coverage prior to services.
- Photo ID and proof of insurance must be presented at check-in.
- Change of patient name or insurance must be advised at check-in.
- Returned checks are assessed a $30.00 return check fee.
- All fees are subject to change without notice.
- An ophthalmic exam does NOT include a contact lens fitting. A fitting for contact lenses will be provided upon my request for an additional charge.
- **THE PATIENT IS RESPONSIBLE FOR** verifying that our physicians are participating on their plan.
- **THE PATIENT IS RESPONSIBLE FOR** obtaining authorizations/referrals when required by their insurance company.
- **THE PATIENT IS RESPONSIBLE FOR** understanding their OWN insurance policy.
  -ANY information provided by Douglasville Eye Clinic staff is not a guarantee of benefits or coverage. Insurance companies state that benefits are only determined once a claim is processed.

ASSIGNMENT OF BENEFITS TO DOUGLASVILLE EYE CLINIC, P.C.: I hereby authorize Douglasville Eye Clinic, to release any information to my insurance company for services rendered to my dependents or to myself in the processing of this claim. I authorize claims to be filed to my insurance plan and payment to be made directly to Douglasville Eye Clinic. This assignment will remain in effect until revoked by me in writing.

MEDICARE PATIENTS ONLY: I request that payment of authorized Medigap benefits be made on my behalf to Douglasville Eye Clinic for any services furnished by supplier. I authorize any holder of medical information about me to be released to _____ including information needed to determine benefits payable for related services. (Name of Medicare secondary insurer)

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

PRIVACY POLICY: I acknowledge that I have been made aware that Douglasville Eye Clinic, P.C. has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that, upon request, I am entitled to a copy of the Privacy Policy.

AGREEMENT FOR COMMUNICATION: I authorize Douglasville Eye Clinic, P.C. to contact me in the following ways to remind me of appointment, provide test results, instructions, or any other information.

Home phone ☐YES ☐NO VOICEMAIL OK? ☐ Work phone ☐YES ☐NO VOICEMAIL OK? ☐

Cell phone ☐YES ☐NO VOICEMAIL OK? ☐ E-mail (Only used on a secure server as required by law) ☐YES ☐NO

I authorize the release of medical information to:

NAME: _____ RELATIONSHIP: _____ PHONE:_____

I have read, understand, and agree to this financial statement. I hereby voluntarily consent to treatment at this office and authorize treatments, examinations, medications, anesthesia, operations and diagnostic procedures (this includes but is not limited to the use of lab and radiographic studies) as ordered by the attending physician.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

DOUGLASVILLE
Eye Clinic

NOTICE OF PATIENT PRIVACY PRACTICES
REVISION DATE 11/12/2014

A. OUR COMMITMENT TO YOUR PRIVACY- The terms of this notice apply to all records containing your PHI. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Compliance Officer 678-838-9999

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. Treatment.
2. Payment.
3. Health Care Operations.
4. Appointment Reminders.
5. Treatment Options.
6. Health-Related Benefits and Services.
7. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.
8. Disclosures Required by Law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. Public Health Risks.
2. Health Oversight Activities.
3. Lawsuits and Similar Proceedings.
4. Law Enforcement.
5. Deceased Patients.
6. Organ and Tissue Donation.
7. Research.
8. Serious Threats to Health or Safety.
9. Military.
10. National Security.
11. Inmates.
12. Workers' Compensation.

E. YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications.
2. You have the right to request a restriction in our use or disclosure of your PHI.
3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice.
5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." .
6. You are entitled to receive a paper copy of our notice of privacy practices.
7. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing to Attn: Compliance Officer.
8. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Discrimination is Against the Law

Douglasville Eye Clinic PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Douglasville Eye Clinic PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Douglasville Eye Clinic PC

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Stacey Osterholt.

Grievance Procedure

If you believe that Douglasville Eye Clinic PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Stacey Osterholt, Compliance Officer

6001 Professional Parkway Suite 2040

Douglasville, GA 30134-5632

Telephone number 678-838-9999, Fax 678-838-9474

Email contact@douglasvilleeyeclinic.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stacey Osterholt, Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.