The ATLANTA VISION Institute

New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ M / F _____ Soc Security # _____

Address _____
Street City State Zip

Phone: Home ( ) Cell ( ) E-mail: _____

Occupation _____ Employer _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

Pharmacy: _____ **Phone:** _____ Work Phone ( ) _____

Referred by : ☐ Friend/Relative _____ ☐ Doctor _____
Name Name

☐ Radio _____ ☐ Internet _____
Station

☐ Billboard ☐ Newspaper ☐ Website ☐ Other _____

INSURANCE INFORMATION (Please Print)

Primary Ins: _____
ID# _____
Group# _____
Ins. Phone # _____
Responsible Subscriber: _____
Subscriber DOB: _____
Subscriber SS# _____

Secondary Ins: _____
ID# _____
Group# _____
Ins. Phone # _____
Responsible Subscriber: _____
Subscriber DOB: _____
Subscriber SS# _____

Who to notifiy in emergency (nearest relative or friend)?

Name: _____ Phone: _____ Relationship: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

PATIENT MEDICAL HISTORY RECORD

The ATLANTA VISION Institute

PATIENT NAME _____ DATE (MM/DD/YY) _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____ PHONE (WORK) _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN'S PHONE _____ PHYSICIAN'S FAX _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any **medical** conditions (e.g., diabetes, high blood pressure, arthritis, etc)?

   Yes ☐ NO☐ If YES, please explain: _____

2. Have YOU ever had any **eye disease**/condition (e.g., glaucoma, cataract, dry eyes, retinal detachment)?

   Yes ☐ NO☐ If YES, please explain: _____

3. Have you ever had any **eye surgery**?(e.g. LASIK, PRK, RK, Cataract, Retinal, Strabismus?)

   Yes☐ No☐ If YES, please provide date _____

4. Do you wear ☐ Glasses, ☐ Soft contacts ☐ Gas Permeable contacts

   Do you experience:☐ dry eyes,☐ eye irritation,☐ glare/halos,

5. Do you take any **medications**? (Cardarone, Accutane, Imitrex?)

   Yes☐ No☐ If YES, please list: _____

   Do you take any **eye medications**: _____

   Yes☐ No☐ If YES, please list: _____

6. Do you have any **drug allergies**?

   Yes☐ No☐ If YES, please list: _____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes☐ No ☐ If YES, please explain: _____

Do you smoke? If Yes, how much? ☐ Drink alcohol? If Yes, how much ☐

Comments

Signature Date

The ATLANTA VISION Institute

Financial Information Policies

Our doctors and staff are very concerned about the cost of your health care and want to address some current issues related to the cost of medical services in this office. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise required for your care.
Our fees are comparable with fees of other surgeons in the metro area. In order to make your financial obligations to our office and keep the necessary insurance paperwork as simple as possible, we ask that you observe the following policies.

Payment Policy

Our policy requires payment at the time of service of your co-pay, deductibles or associated fee for your office visits and procedures. To assist you in filling your own insurance claim, we will provide you with an itemized statement to expedite your reimbursement.

Medicare Members: We will file all claims to Medicare with a valid signature on file. We will also file with your secondary insurance. **Routine eye exams and refractions are not covered by Medicare** and payment is requested at the time of service.

Private Insurance Carriers, Indemnity Policy Holders (NON HMO, POS or PPO): Payment is expected at the time of service for all procedures unless prior arrangements are made. We will provide you with an itemized statement so you can submit to your insurance for reimbursement.
We use many sources to determine the appropriateness of our fees. We cannot and do no allow the payment or allowance of insurance companies to set the amount that we charge for services, should an insurance company indicates a physician's fees are above the "usual or customary".

Health Care Plan (HMO, POS, PPO) Members: A valid authorization is required for all services performed. All claims will be filed to your insurance carrier. Please check your insurance handbook or check with your insurance company before scheduling an appointment to be sure you will be seeing a participating provider. Co-payments are due at the time of service. Contact lenses and glasses are not covered by **Health Care Plan.**

HMO Plans: If you are a member of an HMO, you are responsible to have a current referral from your Primary Care Physician (PCP) prior to being treated with us. You may be sent back to your PCP to obtain one prior to being seen. Failure to obtain a valid referral will result in patient being financially responsible for all charges incurred.

Elective Procedures: Full payment of any elective procedures are due at time of services prior to your procedure taking place.

In your interest, we are pleased to accept most of the majority credit cards. Returned checks will receive a $25.00 overdraft charge. A monthly bill fee will be added to all account balances beyond 30 days from the date of service. A collection agency may take over a delinquent account. If any account is placed in a collection agency, the patient will be responsible for all collection. Timely payment will prevent consequences to your credit rating.

Please bring all health insurance information with you. We will need to copy any insurance cards for our records. Feel free to contact our office if you have any billing or insurance questions. Our staff will be happy to assist you. Your signature below acknowledges the fact that you have read, understand and accept your financial responsibility under this policy.

Print Name:_____

Patient signature:_____ ***Date:***_____

THE ATLANTA VISION INSTITUTE

11459 Johns Creek Pkwy, Ste 100, Johns Creek, GA 30097 (770) 622-2488

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 REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations: Your health information may be used as necessary to support the day-to-day activities and management of The Atlanta Vision Institute. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcment investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Fundraising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the selected box on the consent page that indicates, " Please do not use my information for fund raising purposes."

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.
The right to receive confidential communications concerning your medical condition and treatment.
The right to inspect and copy your protected health information.
The right to amend or submit corrections to your protected health information.
The right to receive an accounting of how and to whom your protected health information has been disclosed
The right to receive a printed copy of this notice.

The Atlanta Vision Institute Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
The Atlanta Vision Institute
11459 Johns Creek Pkwy, Ste 100
Johns Creek, GA 30097

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practice is:

Privacy Officer
The Atlanta Vision Institute
11459 Johns Creek Pkwy, Ste 100
Johns Creek, GA 30097
(770) 622-2488

Effective Date

This Notice has been effective since April of 2003 and has since then been revised and kept current to date: November 2015.

The
ATLANTA VISION
Institute

Comprehensive Eye Examination

We will provide a complete eye examination to you, whether it's your yearly routine eye examination or a medical condition that you may have. If you need a Prescription for glasses, please observe the following for additional information:

If you have Health Care Insurance Coverage:

- All claims will be filed to your insurance carrier. Co-payments are due at the time of service.
- Please provide an updated Medical Insurance card with your picture ID to our front office staff.
- **Additional charge of $25.00 for Prescription for Glasses: Your insurance does not cover the refraction to write a prescription for glasses. Payment is due at time of services.**
- Please inform us prior to dilation if you need a prescription for glasses.

* Refraction charges, **DOES NOT** include contact lens fitting. If you need to get contacts, please inform us in advance for additional costs and possibly a separate appointment time for contact fitting.

Yes, I want to have refraction done for glasses prescription. **$25.00 is due today**.

No, I do not wish to have refraction done today and is not in need of a glasses prescription.

_____ _____

Patient Name Sign Date

_____

Patient Name Print

4/1/2016