Eyesight Associates

A Division of Gayton Health Centre

PATIENT INFORMATION

Legal First Name _____ Middle _____ Last _____

Address:_____ City:_____ State:_____ Zip:_____

County:_____

Home Phone:_____ (Circle) Male / Female (Circle) Single / Married / Widowed / Separated / Divorced

Mobile Phone:_____ Preferred Method of Contact (Please Circle All That Apply): Home # / Work # / Mobile # / Written Communication / E-Mail / Text

Date of Birth_____ Age:_____ SSN#:_____

Race (Circle)
American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / white

Ethnicity (Circle)
Hispanic / Non-Hispanic

Preferred Language (Circle): English / French / Italian / Japanese / Portuguese / Russian / Spanish / Other:_____

Patient Employed By:_____ Wk Phone:_____

Are You Retired? Yes / No Date Retired:_____ Month/Year E-Mail Address:_____ (If you would like access to your visits on the Patient Portal, please provide your E-Mail address.)

How did you learn about our office?_____

Name of Doctor who referred you:_____ City:_____ Phone #:_____

Whom to notify in case of emergency?:_____ Home Phone:_____ Wk Phone:_____

SPOUSE INFORMATION

Name:_____ Employer:_____

Date of Birth:_____ Work Phone:_____

SS #:_____ Retired? Yes / No Date Retired:_____

MUST COMPLETE IF UNDER 18 OR USING GUARDIAN'S INSURANCE

Father

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

Mother

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

**********PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST**********

EYESIGHT ASSOCIATES FINANCIAL POLICY

1. **Proof of Insurance**: Providing quality medical care is our primary goal. We participate with most insurance programs, including Medicare, some Medicaid plans and Tricare as a service to you. You, the patient, have the ultimate financial responsibility for services rendered. If you do not provide proof of valid insurance at the time of service, you will be responsible for all fees upon checkout.
2. **Coverage and Benefits**: Most medical insurance companies do not cover annual vision exams. Some insurance plans offer routine coverage, but ***WE DO NOT PARTICIPATE WITH ANY VISION PLANS.*** If you have questions regarding your coverage benefits, please direct them to your employer or your insurer's representative. It is your responsibility to inform us of any secondary benefits of special requirements, such as Worker's Compensation, or you will be financially responsible for services rendered.
3. **Refraction Policy**: A refraction is performed to determine whether a glasses prescription is needed or an existing prescription needs to be changed. It is also frequently **needed** information for the doctor to monitor the progression of a disease process like cataracts or macular degeneration. There is a separate fee for this test. It is not included in the exam. Most insurance, including Medicare and Medicare Advantage plans, ***DO NOT COVER THIS FEE.*** It will be due at the time of service.
4. **Payment is due when services are rendered**: You are responsible for all co-pays and deductibles required by ***your*** insurance contract. Co-pays or co-insurance need to be paid the day services are rendered. Any non-covered services or treatments that you request or your physician recommends are also your responsibility. As per HCFA guidelines, if you have Medicare or Tricare, and you have a procedure that is sometimes covered and sometimes not, you will be asked to sign an **A**dvanced **B**eneficiary **N**otice form to acknowledge that you understand that you will be responsible for the charges if your insurance does not cover. **ABN**s only apply if a service is sometimes covered and sometimes not. If a service is never covered, you will be asked to pay at the time of service. If you do not have insurance, all fees are due at the time of service.
5. **Our Responsibility to Report Non Compliance**: Many insurance contract request that we report patients who repeatedly refuse to pay co-pays, deductibles, and non covered services or repeatedly "no show" for appointments. Such habits could result in you losing your insurance coverage.
6. **Billing, Payments, and Over Payments**: If an overpayment is made by you, a refund will only be issued if there are no other outstanding debts on you or your family's account. Please inform us of changes in address, phone or employer.
7. **Past Due of Delinquent Accounts**: Failure to meet your financial obligations may result in collection proceedings, which negatively affect your credit score. We reserve the right to add finance charges up to 30% of your balance. If we file your insurance and they have not paid in 45 days, the balance may be transferred to your responsibility.
8. **Returned Check Policy**: All returned checks will be sent to Check Care of Macon, GA and you will be subject to all related fees. You may also be billed a $35.00 returned check fee or any fees that we incur as a result of your check being returned to our bank.
9. **Retail Goods Policy**. Optical and low vision aid orders will not be placed without a deposit. Cancelled or returned items are subject to a $30 non-refundable restocking fee.
10. **Missed Appointment Fee**: Any missed appointments not cancelled or rescheduled 24 hours prior to the appointment time are subject to a $50 fee.

_____ _____

Patient signature Date

Eyesight Associates HIPAA Notice of Privacy Practices

Effective 10/01/2014

— I hereby authorize and request the medical treatment necessary for the care of the above named patient.
— I hereby give my consent for Eyesight Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
— I allow the electronic transmittal of my medical records, if necessary.
— I acknowledge full financial responsibility for services rendered by Eyesight Associates. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
— I may revoke my consent in writing except to the extent that Eyesight Associates has already made disclosures in reliance upon my consent. If I do not sign this consent or later revoke it, Eyesight Associates may decline to provide treatment to me.
— I further authorize and request that insurance payments be made directly to Eyesight Associates should they elect to receive such payment.
— I have received and or read a copy Eyesight Associates Notice of privacy practices that tells me my rights and how Eyesight Associates will use and disclose my protected health information.
— I have received a copy of the financial policy.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

In addition to my primary care physician and/or referring physician, you have my permission to share my medical information with the following:

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Guardian Date of Birth

_____ _____

Patient's Name Today's Date

Eyesight Associates
A Division of Gayton Health Centre
Main Office: 216 Corder Road – Warner Robins, GA 31088
Phone (478) 923-5872 Fax (478) 929-6266

MEDICAL HISTORY QUESTIONNAIRE

Full Name: _____ Preferred name: _____

Primary Care Physician: _____

Pharmacy: _____Location (street & city) _____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes
- □ Diabetes

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling
- □ Fallen X2 in the past year
- □ Injured in fall in past year

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema
- □ Cold Sores

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure
- □ Had Pneumonia shot