



Account # _____

NORTH GEORGIA EYE
ASSOCIATES

PATIENT DEMOGRAPHIC SHEET

(MR/MRS/MS/DR) FIRST _____ MI _____ LAST _____

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

MAILING ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #:(____) ____-____ CELL PHONE #:(____) ____-____ PRIMARY: HOME/CELL

OKAY TO LEAVE VOICEMAIL? YES ___ NO ___ OKAY TO TEXT? YES ___ NO ___

EMAIL: _____ GENDER: (CIRCLE ONE) FEMALE MALE

RACE: _____ PRIMARY LANGUAGE: _____ LANGUAGE BARRIER? YES NO

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____ EMERGENCY CONTACT #:(____) ____-____

PRIMARY CARE PHYSICIAN: _____ PHONE#:(____) ____-____

REFERRING DOCTOR: _____ PHONE#:(____) ____-____

PRIMARY INSURANCE: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Insured DOB: _____ Insured SSN: _____

SECONDARY INSURANCE: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Insured DOB: _____ Insured SSN: _____

Treatment of Minors

Many times, parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I, _____ hereby grant North Georgia Eye Associates to treat my child when they arrive unaccompanied.
(AS LISTED ON HIPPA FORM)

Mothers Name: _____ Cell #: _____ SS#: _____

DOB: _____ Work #: _____ Address: _____

Mother Employer & Address: _____

Fathers Name: _____ Cell #: _____ SS#: _____

DOB: _____ Work #: _____ Address: _____

Fathers Employer & Address: _____

Account # _____



FINANCIAL POLICY

Thank you for choosing North Georgia Eye Associates as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Self-pay Accounts

Self-pay accounts are patients with no healthcare coverage, patients covered by insurance plans in which the office does not participate, and/or patients that do not have their insurance card or insurance information the day of their visit. It is always the patient's responsibility to know if our office is participating with their plan. Self-pay patients will be required to bring payment in full at the initial appointment.

Health Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract, however we will bill your primary insurance as a courtesy to you. You are responsible to pay the usual and customary fees deemed by NGEA for services rendered that are not covered by your insurance like refractions, copays, deductibles and coinsurance. Using medical insurance benefits for a medical eye exam is necessary for the diagnosis/treatment of disease and conditions of the eye performed by a physician or surgeon. I understand that if there is no medical problem, a medical diagnosis will not be made by the physician, Therefore, my medical insurance will not be filed, and I will be financially responsible for services rendered that day.

Vision Insurance Claims

During my exam I will be examined for any needed correction (glasses or contact lenses) or any potential indicators of eye disease. If the provider finds anything abnormal during my vision exam, further testing may be needed at another visit. In that case my medical insurance would be billed. I understand that Routine Vision exams do not qualify for prescribing medications and that contact lens fittings are specific to each individual's needs, and I may be responsible for certain costs not covered under my vision plan.

Workers Compensation

It is the patient's responsibility to provide NGEA with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility.

NORTH GEORGIA EYE ASSOCIATES, LLC. RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS SITE AT ANY TIME.

Patient Signature: _____ Date: _____



HIPPA CONSENT

Patient consent for North Georgia Eye Associates and Gainesville Eye Center to use or disclose health care information for treatment, payment and health care. North Georgia Eye Associates and Gainesville Eye Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, race or gender.

I understand that my health information is private and confidential. I understand that North Georgia Eye Associates and Gainesville Eye Center works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that North Georgia Eye Associates and Gainesville Eye Center may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. You may refuse to sign this consent form.

Under the terms of this consent, I can ask North Georgia Eye Associates and Gainesville Eye Center to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that North Georgia Eye Associates and Gainesville Eye Center do not have to agree to my request. If North Georgia Eye Associates and Gainesville Eye Center do not agree to my request, I understand that North Georgia Eye Associates and Gainesville Eye Center would follow the agreed limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel the consent, I understand that North Georgia Eye Associates and Gainesville Eye Center may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed. I understand it is my responsibility to contact the North Georgia Eye Associates Privacy Officer in writing to terminate the authorization.

I give consent to North Georgia Eye Associates and Gainesville Eye Center to discuss health care information with:

Name	Phone Number	Relationship to Patient

This authorization expires:

- No expiration date.
- Date Specified ____/____/____ -unless revoked or terminated in **writing** by you or your personal patient representative.
- I decline permission to discuss medical information.

Signature of Patient (Guardian if under 18)

Date

Relationship to Patient

North Georgia Eye Associates and Gainesville Eye Center, LLC

PATIENT NAME:	BIRTHDATE: ____/____/____	AGE:	SEX: M F
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LIST ANY PROBLEMS YOU ARE HAVING WITH YOUR EYES OR YOUR GLASSES: _____

PAST EYE SURGERIES/DATES: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	CIRCLE	IF YOU ANSWER YES, PLEASE EXPLAIN
1. Do you have cataracts?	YES NO	_____
2. Have you had cataract surgery? (If so when, where and what surgeon?)	YES NO	_____ _____
3. Glaucoma? (If YES, type of treatment/drops)	YES NO	_____
4. Trauma/Injury (when/what type of injury)	YES NO	_____
5. Ocular Herpes	YES NO	_____
6. Severe Dry Eyes	YES NO	_____
7. Retinal Detachment	YES NO	_____
8. Macular Degeneration	YES NO	_____
9. Abnormal vision during youth	YES NO	_____

FAMILY HISTORY:

RELATIONSHIP TO YOU

1. Eye diseases/blindness (Cataracts, macular degeneration, retinal detachment, glaucoma)	YES NO	Explain: _____
		Circle: Mom/Dad/Sister/Brother/Grandparent
2. Diabetes, Heart disease, hypertension	YES NO	_____
		Circle: Mom/Dad/Sister/Brother/Grandparent
3. Other _____		_____

HAVE YOU EVER USED:

WHEN/HOW LONG

Restasis	YES NO	_____
Xiidra	YES NO	_____
Refresh	YES NO	_____
Systane	YES NO	_____
Other: _____		_____

Patient Signature Date

Doctor Signature Date



GLASSES PRESCRIPTION TEST

Refraction Consent

- Most insurance companies **do not cover** the test for a glasses prescription (a refraction.)
- As a convenience to our patients, we can offer this service at the time of the **medical eye exam** that you are having today.
- The cost for this test is \$40.00, which is less costly than most facilities. **This is separate from your co-pay or deductible due at the end of your visit.**

Would you like to be tested for a prescription for glasses today?

YES _____

NO _____

Patient Signature

Patient Name / DOB (please print)

Staff Member

Date