Augusta Eye MD

PLEASE COMPLETE ENTIRE FORM

Last name: | First: | Middle: | ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Nickname (or preferred name): | Primary Language: | Social Security No.: - - | Race: | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street Address: | City: | State: | ZIP Code:

Mailing address (if different from above): | City: | State: | ZIP Code:

Home phone no.: ( ) | Work phone no.: ( ) | Cell phone no.: ( ) | Email address:

Occupation: | Employer: | Employer phone no.: ( )

Employer Address: | City: | State: | ZIP Code:

Parent/Guardian or Responsible Party (RP): | (RP) Social Security No.: - - | Parent/Guardian or Responsible Party's Address: | (RP) Phone no.: ( )

Parent/Guardian or Responsible Party's Employer: | (RP) Employer address: | Employer phone no.: ( )

Have you ever been a patient here before? ☐ Yes ☐ No | If so, when? | Family seen here:

Primary Care Doctor: | Referring Doctor:

Preferred Pharmacy: | Location

INSURANCE INFORMATION

(Please present your Insurance card(s) at the Check In desk.)

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of primary insurance: | Policyholder's name: | Policyholder's DOB: \ \ | Is the Policyholder currently employed? ☐ Yes ☐ No

Name of secondary insurance (if applicable): | Policyholder's name: | Policyholder's DOB: \ \ | Is the Policyholder currently employed? ☐ Yes ☐ No

Please list any additional insurance policies or pertinent insurance information:

IN CASE OF EMERGENCY

Contact name: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **AEMD** or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

THE REFRACTION

The refraction helps the physician determine your best possible vision. The refraction also determines the prescription required for eyeglasses by evaluating the effectiveness of a series of lenses through which the patient is asked to view an eye chart. The patient will look at a range of lens powers using a refractor, allowing the patient to compare various combinations of lenses when viewing the eye chart. This is also necessary to determine if cataract surgery or laser surgery (after cataract surgery) is needed. This is usually considered ROUTINE by insurance companies and will not pay for this part of the exam. Therefore, this will be the responsibility of the patient. The fee for this is $36.00.

I accept _____ **Date** _____

I decline _____ **Date** _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations as of September 2013

I, _____, understand that as part of my health care, Augusta Eye MD (hereinafter referred to as AEMD) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care including referral for continuation of care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The complete *Notice of Health Information Privacy Policies* is posted on the wall in our office for your review. I understand I may be provided with a copy of *Notice of Health Information Privacy Policies* upon request that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that AEMD is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, AEMD may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that AEMD reserves the right to change their Notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that I may request a updated copy of their notice at any office visit by contacting AEMD Privacy Officer.

AEMD may communicate with the following individuals regarding your treatment (examples are friends, relatives, peers):

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I understand that unless notified in writing otherwise, all communication with me by AEMD will be at the address and phone number supplied by me.

I fully understand and accept / decline the terms of this consent and certify that I am the patient or the Authorized Agent, legal guardian, or Power-of-Attorney holder for the patient listed above and am legally able to sign on behalf of the patient.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.