FAMILY EYE CARE ASSOCIATES

*Please complete all the information requested and print clearly so that your claim can processed quickly and efficiently.

Patient Information

Today's Date: ____________________ Patient Name: ____

Date of Birth:____________________ Email:____

Mailing Address: ____ Apt Number: ______________

City:______________________________State:_______ Zip:______________

Home Phone: ______________________ Cell:______________________

Preferred method of communication: □ E-mail □ Cell phone □ Home phone

Guardian (if under 18): ____

Occupation (Indicate if Student):__________________________ Work Phone Number: ________________

Guarantor (responsible party if under 18): ____________________ Guarantor Phone: ________________

Primary Care Physican:__________________________________

Referring Physician: ____________________________________

Marital Status: (please check) □ Single □ Married □ Divorced □ Widowed

Emergency Contact: __________________________________ Relationship to you: __________________

Contact number/method for Emergency contact:____

Insurance Information

Please return this form with your Driver's License and Proof of Insurance(s). If your name is NOT ON THE CARD, please supply us with the following information:

Subscriber's Name on Card (***if not yours***):__________________________________

Relationship to Patient: (check) □ Self □ Spouse □ Dependent / Gender: (check) □ Male □ Female

Subscriber Date of Birth: ________________

____ ____________________

(Signature of patient or legal representative) (Date)

FAMILY EYE CARE ASSOCIATES

Medical History

Patient Name: ____________________

Please describe the reason for your visit today: ______________________________

Will we be filing today's visit under your wellness plan? ☐ YES ☐ NO

Are you experiencing any of the following ocular symptoms: (circle and specify which eye)

Pain Foreign Body Sensation Dryness Tearing Light Flashes

Double Vision Itching Light Sensitivity Floaters Blurred Vision

Glare at Night Burning Other: ______________________________

____

List Allergies to Medications:		List Current Medications:		List Eye Medications:
________	________	________	________	____________
________	________	________	________	____________
________	________	________	________	____________
________	________	________	________	____________
________	________	________	________	____________

Who is your medical doctor? ____________________ Phone (if you know): ______________

What pharmacy do you use? ____________________ Phone (if you know): ______________

Circle the appropriate answer:

Do you smoke? NO/ YES (Pack Per Day-____) Do you use any other tobacco products? NO/YES-_________

Do you drink Alcohol? NO/YES- ☐ rarely ☐ socially ☐ occasional ☐ moderately ☐ heavy

Do you use any illegal drugs? NO/YES

Please turn over!!

HEALTH HISTORY:

Condition	CHECK **IF** YOU HAVE ANY OF THESE CONDITIONS	**Write: "Mother," Sibling, etc. if any of your family members have these conditions (If not, leave blank)**
Heart Trouble	☐	
High Blood Pressure	☐	
Cholesterol	☐	
Asthma/Emphysema	☐	
Tuberculosis	☐	
Stroke/Palsy	☐	
Diabetes	☐	
Thyroid	☐	
Anemia/Blood disorder	☐	
Hepatitis	☐	
HIV/AIDS	☐	
Arthritis	☐	
Kidney/Bladder	☐	
Stomach/Intestinal	☐	
Mental Disorder	☐	
Cancer/ Tumor	☐	
Head Injury	☐	
Lupus	☐	
Seizures	☐	

Other: ____

PAST SURGICAL HISTORY: ____

____

Eye History	**Check if "yes" for self**	**Relative: Specify Mother, Sibling, etc.**
Lazy Eye	☐	
Cataract	☐	
Glaucoma	☐	
Blindness	☐	
Eye Injury	☐	
Eye Surgery	☐	
Crossed Eyes	☐	
Retinal Detachment	☐	
Macular Degeneration	☐	
Glasses/Contact Lens Wearer	☐	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

______________________________ ______________

Signature of Patient, Parent, or Guardian *Date*

Family Eye Care Associates

111 Fieldstone Drive Suite 1 | MILLEDGEVILLE GA, 31061 | (478) 453-9333
www.familyeyemilledgeville.com

Written Financial Policy

Thank you for choosing Family Eye Care Associates. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Our office accepts:

- Visa®, MasterCard®, American Express®, Discover Card®, CareCredit Credit Card®* or Cash/check

Please note:

It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. A refraction is a measurement of the lens power necessary to write a prescription for glasses or other corrective lenses. Most medical insurance plans, including Medicare, **do not cover routine refractions or routine eye exams** (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.

Family Eyecare Associates does not accept Vision Insurance Plans. You are welcome to file with your vision plan and we can provide you with the required documentation.

MINORS ACCOMPANIED BY AN ADULT; The adult accompanying a minor and his/her parents (or guardian) are responsible for payment prior to the beginning of your exam or consultation.

In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments after your exam.

Family Eye Care Associates requires a 50% deposit collected prior to placing order of your optical purchase.

Family Eye Care Associates will collect all current and past due balances at the time of the service.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

____
Patient, Parent or Guardian Signature Date

____
Patient Name (Please Print) Date

**CareCredit is a healthcare credit card providing special financing and payment options for out-of-pocket medical expenses. Ask about how the CareCredit healthcare credit card can help you.*

FAMILY EYE CARE ASSOCIATES

REFRACTION SERVICE FEE

A refraction is the process of determining your best corrected vision. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses as well as surgical evaluations. We are required to bill separately for this procedure.

Traditional Medicare (Red, White, and Blue card) never covers routine vision or dental services.

Our office fee for a refraction is $20.00. Should your plan pay us for the refraction, we will reimburse you accordingly.

□ ***I consent* to having a refraction done today for a prescription (for glasses or contact lenses) and understand that it is not a covered part of my exam.**

______________________________	________________
Patient Signature (or guardian)	**Staff Witness**

-OR-

□ ***I decline* the refraction today and understand that without a current glasses prescription, I will not be able to get glasses or contacts lenses and/or reschedule relevant appointments for surgical evaluation.**

______________________________	________________
Patient Signature (or guardian)	**Staff Witness**

THE FOUNDATION OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY
Advancing Lifelong Ophthalmic Education

Internal Use:
ACCT#____________________

DATE: ____________________

FAMILY EYE CARE ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices (updated September 2013), which states how we may use and/or disclose your health information. A copy is available on our website (www.familyeyemilledgeville.com) and our patient portal. Please sign this form if a NOPP has been made available to you. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that this office's Notice of Privacy Practices has been made available to me.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐The patient refused to sign.

☐Due to an emergency situation it was not possible to obtain an acknowledgement.

☐We weren't able to communicate with the patient.

☐Other *(Please provide specific details)*

____

____

____

______________________________ ______________________

Employee signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.