GEORGIA RETINA

Dear Patient:

Your doctor has referred you to Georgia Retina, PC and we look forward to meeting you. We are board-certified ophthalmologists who specialize in diagnosing and treating problems of the retina, vitreous and macula. We look forward to providing your retinal specialty care. If you are unable to keep your appointment, please call us and we will arrange another date or time.

Because of the comprehensive nature of your visit, please have someone accompany you to your appointment. In addition to being a valued participant in our discussion of your eye problem, it is advised that you have a companion drive you home, as your eyes will be dilated.

Please be prepared to spend at least two hours with us. In that time, we will gather a full medical history and perform an eye examination-including dilation of the pupils and possibly special diagnostic testing such as retinal photography, fluorescein angiography, optical coherence tomography, or ultrasonography. After your examination, we will thoroughly explain our findings, discuss your condition with you, and make treatment recommendations.

In order to better familiarize us with your general and ocular health, as well as expedite your visit, please fill out the Patient History Form. All new patient forms may be downloaded from our website at www.garetina.com. Also, please bring any prescription glasses you may wear or a copy of your eyeglass prescription, any medication and eye drops you are currently using, and a list of names and addresses of the physicians that you currently see so that we can keep your doctors informed of your evaluation.

Be sure to bring all your insurance cards and photo ID with you when you come for this appointment. We participate with many insurance plans as well as Medicare. Payment for any co-payment and/or deductible is required at the time of your visit and may be made by cash, check or credit card. Payment for any estimated co-insurance amount will be requested at the time of service as well. Non-insured patients should arrive prepared to pay a minimum of $250 for the initial visit services. *Please understand that your failure to maintain a current account with us may result in the suspension of treatment and/or your dismissal from the practice.*

If you have any questions, please call us at one of our offices listed below. Our office hours are 8:30a.m. to 5:00p.m., Monday though Friday. Retina specialist coverage is available 24 hours a day, seven days a week.

Sincerely,

The Staff and Doctors at Georgia Retina, P.C.

GEORGIA RETINA

PATIENT INFORMATION

(MR / MRS / MS / DR) FIRST_____ MIDDLE_____ LAST_____

DATE OF BIRTH_____AGE_____MARITAL STATUS (circle one) Married / Divorced / Single / Widowed

MAILING ADDRESS_____APT/LOT/ROOM/SUITE_____

CITY_____STATE_____ZIP_____GENDER (circle one) MALE / FEMALE

HOME PHONE_____CELL PHONE_____SSN_____

PREFERRED LANGUAGE_____RACE_____ETHNICITY_____

EMAIL_____

EMERGENCY CONTACT_____ PHONE_____

REFERRING DOCTOR _____ LOCATION_____ PHONE_____

PRIMARY CARE DOCTOR_____ LOCATION_____ PHONE_____

PREFERRED PHARMACY_____LOCATION_____PHONE_____

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

COMPLETE THIS SECTION **ONLY IF INSURANCE HOLDER IS SOMEONE OTHER THAN PATIENT.*

NAME OF POLICY HOLDER_____ DATE OF BIRTH_____

SSN_____ RELATIONSHIP TO PATIENT (circle one) SPOUSE / CHILD / OTHER

NOTICE OF PRIVACY POLICY – PATIENT ACKNOWLEDGEMENT

I,_____, hereby authorize Georgia Retina, P.C. to furnish information to insurance carrier(s) concerning my diagnosis and treatment. I authorize Georgia Retina, P.C. and affiliated business associates to contact me regarding appointments and billing inquiries. I acknowledge that I was offered a copy of the Notice of Privacy Practices policy issued by Georgia Retina, P.C. on the date indicated below. I also specifically authorize Georgia Retina, P.C. to discuss my personal health information with the following people:

NAME:	RELATIONSHIP:	PHONE NUMBER(S):
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE_____ DATE_____

Name of Legal Guardian (if other than above)_____Relationship to Patient_____

WITNESS_____ DATE_____

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PATIENT MEDICAL HISTORY

Name:_____ DOB:_____

Have you ever been treated for the following?

Y / N	Diabetes	Date of Onset:_____	**Y / N**	Cancer	Date of Onset:_____
Y / N	High Blood Pressure	Date of Onset:_____	**Y / N**	Abnormal Bleeding	Date of Onset:_____
Y / N	High Cholesterol	Date of Onset:_____	**Y / N**	Autoimmune disease	Date of Onset:_____
Y / N	Heart Disease	Date of Onset:_____	**Y / N**	Gastrointestinal problems	Date of Onset:_____
Y / N	Kidney Disease	Date of Onset:_____	**Y / N**	Hepatitis A / B / C	Date of Onset:_____
Y / N	Lung Disease	Date of Onset:_____	**Y / N**	AIDS/HIV	Date of Onset:_____
Y / N	Liver Disease	Date of Onset:_____	**Y / N**	Born Prematurely	
Y / N	Stroke	Date of Onset:_____	**Y / N**	Are you or could you be pregnant?	

List any other health conditions:_____

_____

_____

Please list the following:

General surgeries (including date):_____

_____

Eye procedures and/or surgeries (please include date and doctor):_____

_____

Current Medications/dosage:_____

_____

Eye Medications:_____

Drug Allergies & Reactions:_____

Family history of eye disease? **Y / N,** What disease?_____

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PATIENT MEDICAL HISTORY

Smoker? **Y / N,** If yes, pack/day_____for_____years.

Past Smoker? **Y / N,** If yes, when did you quit? _____How many packs per day before quitting?_____

Alcohol? **Y / N,** If yes, _____drinks per day/week/social?

History of prescription or non-prescription drug or alcohol abuse? **Y / N**

Marital Status: **S / M / D / W**, Number of children:_____, Occupation:_____

Do you live: (circle one) **alone, with friends/family, in a nursing home**

Have you recently experienced any of the following symptoms? If so, please circle.

Constitutional	Fever / weight loss / fatigue / loss of appetite/ none
HENT	Hearing loss / sore throat / runny nose/ none
Cardiovascular	Chest pain / shortness of breath / swelling of feet/ none
Respiratory	Wheezing / cough/ none
Endocrine	Excess thirst or urination / hot or cold intolerance/ none
Gastrointestinal	Abdominal pain / nausea / diarrhea/ none
Genitourinary	Blood in urine / pain upon urination/ none
Integumentary	Rash / changes in mole/ none
Musculoskeletal	Muscle aches / joint pain / discomfort in certain postures/ none
Neurologic	Weakness /scalp tenderness / headaches / tremor/dizziness/ none
Hematology	Easy bruising / prolonged bleeding/ none
Diabetic	Neuropathy / nephropathy (kidney) / dialysis / none

GEORGIA RETINA

FINANCIAL POLICY AGREEMENT (FPA)

Thank you for choosing Georgia Retina, P.C., to treat your retinal condition. We are committed to excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA and the Patient Information Form (PIF) prior to receiving any medical care from us.

Please initial and then sign the following:

_____ 1. Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances and deductibles are to be paid in full at each visit and prior to any surgery. Your insurance policy is a contract between you and your insurance company. We accept cash, checks and major credit cards

_____ 2. As a courtesy, Georgia Retina will file claims to your insurance carrier(s). To accomplish this, you must provide all insurance policy information and changes to our office. If the insurance company(s) that you designate is incorrect, you will be responsible for payment of the visit. Your bill is your responsibility, whether or not your insurance company pays.

_____ 3."Self pay" patients (and patients with limited health insurance) are required to pay 100% of services rendered at each visit. A minimum of $250 is expected on the initial visit. For extended treatments, payment arrangements are available and can be made with the front office staff prior to any medical evaluation, procedure or treatment.

_____ 4. Bills unpaid for more than 60 days will be turned over to a third party and/or collection agency. Additional fees may be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____ 5. As a specialty group, some insurance companies require that an authorization or referral be obtained prior to your visit. It is your responsibility to know if your insurance requires this and to obtain the referral/ authorization. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

_____ 6. A $30.00 fee will be charged on all returned checks.

_____ 7. From time to time, you may ask us to complete various forms (such as disability forms). There is a $25 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 7 to 14 business days.

_____ 8. We may charge up to $25 for the reproduction of your medical records based on guidelines from the State of Georgia and the Federal Government.

_____ 9. *I understand that failure to maintain a current account with Georgia Retina may result in further non-emergent medical treatments not being provided and/or dismissal from the care of Georgia Retina.*

_____ 10. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to Georgia Retina, P.C., for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

By signing below, I acknowledge receipt of this FPA.

X_____ X_____Date ___/____/_____

Signature of patient or responsible party Georgia Retina, P.C., representative