Please Provide Photo ID and Insurance Cards For Copying

Primary Insurance: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____

Secondary Insurance: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____

Worker's Compensation: _____

Injury Date Contact person Phone #

Authorization Assignment of Benefits

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Georgia Vision Institute, PC for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers For Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor, and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

MEDIGAP OR OTHER SECONDARY INSURANCE

I also request that the payment of authorized Medigap benefits or other secondary insurance be made either by me or on my behalf to Georgia Vision Institute, PC or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature: _____ **Date:** _____

Refraction Services

Refraction is the process of determining the need for glasses or contact lenses. It is an essential part of an eye examination, but is considered a **non-covered service** by Medicare and many insurance companies; thus it becomes the responsibility of the patient. Our office fee for refraction is $35.00 and this fee is collected at the time of your visit in addition to any co-payments.

I have read the above information and understand that the refraction is a non-covered service. I accept financial responsibility for the cost of the refraction and understand it is separate from and not included in the insurance co-pay.

Signature: _____ **Date:** _____

Privacy Notice

I acknowledge that a copy of the Privacy Notice of Georgia Vision Institute, P.C. is available upon request.

Signature: _____ **Date:** _____

GEORGIA VISION INSTITUTE PATIENT INFORMATION SHEET

Name: _____ **Sex:** _____ **Age:** _____
Last First MI

Date of Birth: _____ **Soc. Sec. Number:** _____ **Email Address:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Home Address: _____

Preferred Contact: ____ Home Phone ____ Cell Phone ____ Work Phone ____ Other _____

Preferred Language: ____ English ____ Spanish Other_____

Race: ____ White ____ Asian ____ Black/African American ____ Prefer Not To Answer

____ American Indian/Alaskan Native ____Native Hawaiian/Pacific Islander

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino Origin ____ Prefer Not To Answer

Patient's Employer: _____ **Occupation:** _____

Marital Status: _____ **Spouse's Name:** _____

If Patient is a Minor, List Parent/Guardian Name: _____

Emergency Contact: _____
Living Outside Your Home: Name Relationship Phone

Referring Doctor: _____

Primary Care Doctor: _____

____ I give Georgia Vision Institute permission to leave a message on an answering machine/voicemail pertaining to my care. This may include appointment information, billing/insurance information and/or lab and test results.

____ I give Georgia Vision Institute permission to share information pertaining to my care with the following individuals. This may include appointment information, billing/insurance information, lab/test results and/or discussions regarding my general care.

_____
Name Relationship

_____
Name Relationship

____ I do not give permission for Georgia Vision Institute to share information pertaining to my care with anyone.

Signature: _____ **Date:** _____