



New Patient Information				
Account Number		Incoming Complaint (What problems are you having with your eyes?)		
Date				
Patient Information				
Name (Last, First, MI)				Mr. Mrs. Ms. Dr. Other:
Date of Birth		Social Security Number		Race
Mailing Address - Street		City	State	Zip
Home Phone		Cell Phone		Work Phone
E-mail address				
Employer			Occupation	
Who should we contact in case of an emergency (nearest friend or relative)?				
Name:		Relationship:		Phone:
List those with whom we are authorized to discuss and/or release details concerning your medical/financial information.				
Responsible Party Information <input type="checkbox"/> Same as Patient				
Name (Last, First, MI)				Mr. Mrs. Ms. Dr. Other:
Date of Birth		Social Security Number		
Address - Street		City	State	Zip
Home Phone		Cell Phone		Work Phone
Insurance Information				
Primary Insurance		Policy Holder's Name		Employer
Secondary Insurance		Policy Holder's Name		Employer
Policy Holder Information <input type="checkbox"/> Same as Patient				
Name (Last, First, MI)				Mr. Mrs. Ms. Dr. Other:
Date of Birth		Social Security Number		
Address - Street		City	State	Zip
Home Phone		Cell Phone		Work Phone
Referral Information				
How did you hear about our office?		Radio	T.V.	Newspaper
		Word of Mouth	Doctor	
Doctor's Name:				

Treatment Consent

By signing below I authorized the physicians and medical staff of Eye Physicians and Surgeons of Augusta, P.C. to administer such treatment as is medically necessary. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I understand this authorization is voluntary and that I have the right to revoke it in writing, at any time.

Patient/Responsible Party Signature

We have included the following policies for your review. If you have any questions or concerns, do not hesitate to ask a staff member.

Non-Covered Services/Refractions

There may be services that your insurance policy does not cover. Examples of non-covered services are refractions, eyeglasses (except for Medicare recipients who receive the first pair following cataract surgery), cosmetic surgery and injections. It does not mean that these are services that you do not need. It only means that your insurance policy does not include them in your coverage, and that you are personally responsible for paying for those services in full.

The only non-covered service that is routinely a part of your eye exam is the Refraction. Please understand that if you decline the Refraction we will be unable to prescribe new glasses for you or prescribe a change in your existing glasses since the Refraction is the test necessary to determine your glasses prescription. We will also lose the ability to evaluate your best correctable vision in order to rule out decreased vision that may be caused by a medical condition. The Refraction is never a covered service by Medicare and rarely covered by Private insurances.

Understanding the above, if you still wish to decline the Refraction, please let the technician know at the beginning of your exam.

Release of Information

Eye Physicians and Surgeons of Augusta, P.C. may disclose all or any part of your medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person, corporation, or insurance company (1) to provide you with medical treatment or services, or (2) to obtain reimbursement for services rendered, or (3) for health care operations necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes.

Financial Agreement/Assignment of Benefits

Eye Physicians and Surgeons of Augusta, P.C. is a participating provider for most private Insurance Companies and will file your insurance claim for you. Because we are a participating provider for most insurance companies, we have a contracted amount the insurance company has agreed to pay us for any covered service or procedure. If you have a co-payment, coinsurance and/or a deductible we ask that you pay these amounts on the date of service. In the unlikely event an overpayment occurs, it will be reimbursed to your insurance company or to you within 30 days. If your insurance company requires a referral, we ask that you obtain that referral prior to your appointment.

By signing below (1) you acknowledge that you understand the above policies and that a copy of this authorization may be used in the place of the original, and (2) you authorize any benefits payable on your behalf or on behalf of the patient to be paid to Eye Physicians and Surgeons of Augusta, P.C.

Patient/Responsible Party Signature

Date: _____