Welcome to Advanced Family Eyecare!

Tell us about YOU!

Last Name: _____ Gender: M/F

First Name: _____ Middle Initial: _____ Date of Birth: _____

Title: _____ Suffix: _____ Social Security #:_____

Nickname: _____ Marital Status: Single/Married/Divorced/Widowed

Address: _____ Employer Status: _____

City: _____ Employer: _____

State: _____ Zip Code: _____ Occupation: _____

Home Phone: _____ Preferred Language: _____

Daytime Phone: _____ Race: _____

Cell Phone: _____Text OK? _____ Ethnicity: _____

Email Address: _____

How would you like us to contact you (circle one)? Email Telephone Postal

How did you hear about us? _____

Patient Privacy

- **A copy of our privacy policies is posted in our waiting area and on our website madisoneyes.com. Free copies are available at our front desk. Per HIPAA guidelines, your consent is necessary for our office to discuss your eye care with others except for the exclusions listed in our policies. Please list below those you wish to allow us to discuss your care with.**

  - Name:_____ Relationship:_____
  - Name:_____ Relationship:_____
  - Name:_____ Relationship:_____

Office policies and procedures

- **Our office policies and procedures are available for review at our website *madisoneyes.com* or at our front desk. These policies include but are not limited to: contact lens fitting and refraction fees, eyeglass order policies, insurance filing, late fees for unpaid bills and emergency visit policies. If you have any questions at any time, feel free to ask one of our staff members.**

I acknowledge and accept the office and privacy policies of Advanced Family EyeCare.
I do ◯ I do not ◯ grant this office permission to bill my insurance company for any care I receive. I understand if medical eye conditions are being followed or treated, my medical insurance will be billed. If applicable, I grant permission for the minor under my care to be examined, diagnosed and treated if they are the patient here for care.

Sign _____ Date _____

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Patient Questionnaire

1. Primary Care Doctor _____

2. Preferred pharmacy _____

3. Past eye history (Circle all that apply)
   a. Cataracts
   b. Macular degeneration
   c. Glaucoma/risk of glaucoma
   d. Diabetic retinopathy/bleeding in eye from diabetes

4. Health history (Circle all that apply):
   a. Diabetes
   b. High Blood pressure
   c. High cholesterol
   d. Cancer
   e. Auto-immune disease (Lupus, Sjogren's, etc)

5. Family eye history (Circle all that apply)
   a. Cataracts: father/mother/brother/sister
   b. Macular degeneration: father/mother/brother/sister
   c. Glaucoma/risk of glaucoma: father/mother/brother/sister
   d. Diabetic bleeding in eye from diabetes: father/mother/brother/sister

6. Family Health history (Circle all that apply):
   a. Diabetes: father/mother/brother/sister
   b. High Blood pressure: father/mother/brother/sister
   c. High cholesterol: father/mother/brother/sister
   d. Cancer: father/mother/brother/sister

7. Current medications:
   a. _____ Dose: _____
   b. _____ Dose: _____ _____
   c. _____ Dose: _____
   d. _____ Dose: _____

8. Medication allergies
   a. _____ Type of reaction: _____
   b. _____ Type of reaction: _____
   c. _____ Type of reaction: _____

9. Do you smoke? **Y/N** Drink Alcohol? **Y/N** Take Narcotics? **Y/N**

Sign _____ **Date**_____

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Medical insurance versus Preventative Vision Benefits:

Optometrists care for both "routine eye care" and medical eye care. If you have coverage for both, we will bill according to your complaint, diagnosis and previous orders from Dr. Tennant and any past eye doctors you may have seen.

Preventative vision benefits cover diagnosis and treatment of BLURRED VISION COMPLAINTS caused by nearsightedness, farsightedness, reading focus problems, etc. Such conditions can be treated fully and simply with glasses and/or contact lenses. Included in a preventative eye exam is an eye health assessment. Such an assessment is performed on a healthy eye to detect eye disease early in its progression. Whenever an eye disease is detected and needs to be treated or followed, preventative eye exams are no longer appropriate in the care of your eyes, and your medical benefits will be used.

Medical benefits pay for eye exams when your complaint and diagnosis (present or past) involve a medical condition. A **partial** list of such conditions/complaints includes diabetic eye exams, medically significant cataracts, pink eye, the monitoring of high-risk medication side effects on the eye (Tamoxifen and Plaquenil), glaucoma, the suspicion of glaucoma, sudden vision loss, flashes and floaters before your vision, foreign body in the eye, following intraocular lenses (IOLs) after surgery, *etc*. In addition, in the case your exam results in a referral to a specialist and our office generates a referral letter and coordinates making an appointment for you, the exam is considered medical. **In these cases, your eye exam will be billed through your medical insurance, and any medical co-pays or co-insurance will be collected today at the conclusion of your exam.**

To put this into the simplest form, if your eye exam is more complicated than "Your eyes are doing great! Here is your prescription for glasses and/or contacts. We will see you in a year", your exam is probably medical. If you have any questions about this, please have a discussion with the staff or Dr. Tennant before your exam.

I have read and understand the preceding statement. I give permission to Dr. Tennant and the staff of Advanced Family EyeCare to bill out my exam consistently with this form.

Name Date

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Office Payment Policy

Payment for services is due at the time services are rendered. We accept cash, checks, and major credit cards. As a service to our patients, we are happy to file your insurance claims as long as you provide a current insurance card and accurate information for filing. Please note the following items:

1. Not all services are covered by insurance plans. Non-covered service charges are your responsibility. For example, refraction (the process Dr. Tennant uses to determine a prescription for your eyes that gives you your best vision) is $41.

2. Copayments and deductibles are due at the time services are rendered.

3. Benefits quoted by your insurance company are not a guarantee of payment. If you were covered by a wellness plan, it is your responsibility to inform our staff with the provisions included in your policy.

4. After 60 days, any balance still outstanding on your account, regardless of any insurance claim, that becomes your responsibility and we expect payment in full at that time. Should this happen? We appreciate your contacting your insurance company as Georgia law requires either payment or an explanation of nonpayment within 60 days of filing.

5. If you are unable to pay your outstanding balance in full at that time, please call us to arrange payments. You will be required to sign a payment plan agreement.

6. Balance is older than 75 days are reviewed and turned over to collections or directed for legal remedy. Subsequently you will be responsible for a $25 finance charge on collection balances, as well as associated legal fees in case of litigation.

7. Return checks are subject to a $30 check fee.

8. We make every effort to accommodate patients who need care therefore appointments canceled with less than 24 hour notice or no-shows will be billed a $35 fee to schedule another appointment with our office. After three missed appointments, the patient may be dismissed from the practice.

9. We accept Medicare assignment and file claims for Medicare. If Medicare is your only insurance, you'll be responsible for paying the deductible and 20% coinsurance at the conclusion of your visit.

Please remember that you the patient or financially responsible for the treatments you receive at advanced family eye care of Madison, PC. If have special financial needs, please discuss them with the front desk or Dr. Tennant before your appointment.

I agree to notify advanced family eye care of Madison, PC if my insurance company/coverage should be canceled or changed.

I have read and understood above policy and agreed to abide by these terms.

Patient signature _____ **Date** _____

Date of birth _____