Surgery Partners Affiliated Covered Entity (SPACE)

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____	_____	_____
PRINT PATIENT'S NAME	**DATE OF BIRTH**	**DATE**

AGREEMENT OF RESPONSIBILITY

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand I am financially responsible for charges not covered by my insurance company.

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

I understand that Novamed Eyecare Services, LLC ("NovaMed") has been engaged to manage Omni Eye Services of Atlanta. And hereby authorized NovaMed, its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its management functions and as they deem necessary for so long as NovaMed is engaged as manager.

MEDICARE AUTHORIZATION **MEDICARE NO: _____**

I request payment of authorized Medicare benefits be made on my behalf to Omni Eye Services of Atlanta for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance's is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP AUTHORIZATION **INSURANCE CO._____** **POLICY#:_____**

Fill out if you have Medigap Insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplement policy is a health Insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain cost that Medicare does not pay. By law, this excludes a policy or plan offered by an employer or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This Agreement is in effect until revoked in writing by the patient.

Please sign below to acknowledge receipt of privacy notice, agreement of responsibility, consent to treat and release of information/assignment of benefits.

X_____

SIGNATURE

If Personal Representative's signature appears above, please describe Personal Representative's Relationship to patient: _____

Patient Information

DEMOGRAPHICS

NAME LAST FIRST MI	DATE
STREET ADDRESS	SOCIAL SECURITY #

CITY	STATE	ZIP CODE	PREFERRED LANGUAGE (Circle) ENGLISH SPANISH OTHER _____

BIRTHDATE	AGE	SEX F ☐ M ☐	RACE (circle): American Indian/Alaska Native Asian Black/African American Hawaiian/Pacific Islander Caucasian Other _____

CELL PHONE ( )	HOME PHONE ( )	WORK PHONE ( )	ETHNICITY (Circle) Hispanic/Latino Unknown Other_____

EMPLOYER NAME/ADDRESS	PHARMACY NAME, LOCATION, TELEPHONE #
SPOUSE NAME	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT	PHONE ( )	PATIENT'S PERSONAL E-MAIL ADDRESS

PLEASE FILL OUT THIS AREA TO LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE

NAME OF OPTOMETRIST	PHONE ( )	☐ PATIENT NAME_____ ☐ OTHER PHYSICIAN_____ ☐ OTHER (INSURANCE, YELLOW PAGES)_____ _____
LOCATION		

STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE MEDICAL DOCTOR NAME		PHONE ( )	
STREET ADDRESS	CITY	STATE	ZIP CODE

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER
STREET ADDRESS	PHONE ( )

CITY	STATE	ZIP CODE

PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	Social Security #	INSURED'S Date of Birth
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	Social Security #	INSURED'S Date of Birth

SEND WORKERS COMPENSATION BILL TO	AUTHORIZED BY/POSITION	DATE OF INCIDENT

PATIENT HISTORY FORM

NAME_____DOB_____DATE_____

Chief Complain/Reason for my visit:
Location: **Which Eye?**
Quality: **What are you experiencing?**
Severity: **How bad is it?**
Duration: **When did the problem start?**
Timing: **How long does it usually last?**
Context: **In what setting does it occur?**
Modifying Factor: **What makes it better or worse?**
Associated Symptoms: **Other symptoms that occur?**
Treatments: **How have you treated the problem?**

Referring Optometry_____ Primary Care Doctor_____

Do you have any allergies?

□No □Yes, please list _____

Do you use tobacco, alcohol or recreational drugs?

□No □Yes, please comment _____

Family Medical History – Does anyone in your family have the following?

□Glaucoma □Diabetes □Cross Eyes □None

□Blindness □Cancer □Heart Disease

□Other _____

Please list names and doses of all medications you take:			
Medication	**Dosage**	**Medication**	**Dosage**

List all previous operations/ treatments/ injuries/ illnesses	
Date	**Description**

Additional comments:

REVIEW OF SYSTEMS

NAME_____**DOB**_____**DATE**_____

Please check those things which apply to you.

Eyes

□Glasses
□Contacts
□Pain
□Redness
□Discharge
□Tearing
□Itching
□Swelling
□Light Sensitivity
□Floaters
□Double Vision
□Distortion
□Loss of Color
□NONE

Cardiovascular

□Chest pain/ Angina
□Heart Attack
□High Blood Pressure
□Irregular Heartbeat
□Heart Murmur
□NONE

Respiratory

□Asthma
□Emphysema
□Shortness of Breath
□Productive Cough
□Tuberculosis
□NONE

Musculoskeletal

□Muscle Cramps/ Spasm
□Weakness
□Arthritis
□Aching Joints
□Swelling Joints
□NONE

Gastrointestinal

□Special Diet
□Abdominal Pain
□Indigestion
□Nausea/ Vomiting
□Liver Disease
□Diarrhea/ Constipation
□Passing Blood
□Change in Stool Color
□NONE

Genitourinary

□Kidney Stone
□Infections
□Burning Urine
□Genital Discharge
□Dialysis
□NONE

Endocrine

□Excessive Sweating
□Heat/ Cold Intolerance
□Severe Thirst
□Altered Menstrual Cycle
□Infertility
□NONE

□ HIV Positive

Constitutional Problems

□Fatigue
□Fever
□Weight Loss
□Loss of Appetite
□NONE

Skin and/ or Breast

□Rashes
□Change in Skin Color
□Loss of Hair
□Breast Lumps/ Surgery
□NONE

Diabetes Controlled By

□Diet
□Insulin
□Oral Medication
□NONE

Ear/Nose/Mouth/ Throat

□Ringing Ears
□Difficulty Hearing
□Difficulty Chewing
□Difficulty Swallowing
□Difficulty Speaking
□NONE

Psychiatric

□Memory Loss
□Poor Concentration
□Sleeplessness
□Early Waking
□Depression
□Anxiety Attacks
□NONE

Neurological

□Stroke
□Epilepsy
□Headaches/ Migraines
□Loss of Balance
□Numbness/ Tingling
□Tremors
□NONE