

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: _____

VISUAL FUNCTION QUESTIONNAIRE

Please Check All That Apply to You

Have you been bothered by:

- | | |
|--|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Seeing in poor or dim light |
| <input type="checkbox"/> Hazy vision | <input type="checkbox"/> Halos |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Seeing rings or stars around lights |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Frequent changes in glasses |

Have you noticed difficulty with your vision when you:

- | | |
|--|--|
| <input type="checkbox"/> Work at your job | <input type="checkbox"/> Shop for groceries |
| <input type="checkbox"/> Manage your home | <input type="checkbox"/> Drive during daylight hours |
| <input type="checkbox"/> Get around in your home | <input type="checkbox"/> Drive during evening/ night hours |
| <input type="checkbox"/> Watch TV | <input type="checkbox"/> See traffic signs |
| <input type="checkbox"/> Use a computer | <input type="checkbox"/> Sew or do crafts |
| <input type="checkbox"/> Read newspapers | <input type="checkbox"/> Play golf |
| <input type="checkbox"/> Read the telephone book | <input type="checkbox"/> Enjoy recreation or leisure |
| <input type="checkbox"/> Read labels | <input type="checkbox"/> Recognize people |
| <input type="checkbox"/> Read price tags | <input type="checkbox"/> Other _____ |

Patient's Signature: _____

Date: _____ Reviewed by: _____



CATARACTS AND YOUR IOL OPTIONS

Medicare and all other insurance companies allow patients to choose from among several new premium lens implants. These new technology lenses, such as the ReStor and Symfony lenses (corrects vision for all distances: far, computer and up close) and the Toric lens (corrects vision for astigmatism) ARE NOT COVERED BY ANY INSURANCE PLAN, but you still may take advantage of them by paying out of pocket. **We will discuss all options during your evaluation.**

Monofocal Lens (Standard)

The traditional lens implant corrects your vision for distance only. Unless you have a significant amount of astigmatism, you will likely be able to see well at distance with minimal reliance on glasses. However, your reading and computer range of vision will most likely be completely blurred and you will need reading glasses. Typically, Medicare and private insurance pays 80% of your surgery with this lens implant. Supplemental insurance may cover a good portion of the rest. There is often a balance related to any unmet deductible that will be collected on the day of surgery.

Astigmatism Lens (Toric)

The Toric Lens is for patients with astigmatism who would like to be able to see as clearly as possible in the distance (Driving, TV) without relying on glasses. You will still need reading glasses and won't see well for reading or computer without them. This lens is not covered by insurance but you are allowed to pay the difference to upgrade to this technology to have your astigmatism corrected with your intraocular lens.

Multifocal Lens (ReStor or ReStor Toric)

The ReStor Lens is for those patients who would like less dependence on glasses. It should provide good vision at distance, intermediate range, and up close without glasses for most people. This lens is designed to improve your vision at all distances without glasses, but glasses may be necessary to enhance visual quality. There may still be situations such as reading in dim light, reading small print, or driving where glasses are necessary. Glare and halos around lights are possible. A Toric version is available for people with larger amounts of astigmatism. Medicare and other insurance companies do not cover this lens but do allow you to pay for the upgrade. This can be discussed in detail with your doctor and staff if you are interested.

Extended Depth of Focus Lens (Symfony or Symfony Toric)

The Symfony Lens is for those patients who would like less dependence on glasses. It should provide good vision at distance and intermediate range without glasses for most people. It can provide good reading vision, but perhaps not as close to your face as some are used to. The advantage of the Symfony Lens is for those who do more computer work than reading, and for those who wish to rely less on glasses at all distances. Those that choose the Symfony lens are more likely to achieve improved intermediate and distance vision. There may still be situations such as driving, reading close up, reading in dim light or reading small print where glasses are necessary. A Toric version is available for people with larger amounts of astigmatism. Its unique optics also provides reduced levels of halos when compared to traditional multifocal IOLs. However, glare and halos around lights are still possible.

Please let us know if you would like to discuss the new technology lenses with your Surgeon.

Yes, I would be interested in learning more about the new technology lenses mentioned above. I understand they are not covered by insurance.

No, I want just the standard lens that is covered by insurance.

Signature _____ Date _____

Patient Information

DEMOGRAPHICS

NAME <small>LAST FIRST MI</small>						DATE	
STREET ADDRESS						SOCIAL SECURITY #	
CITY			STATE	ZIP CODE	PREFERRED LANGUAGE (Circle) ENGLISH SPANISH OTHER _____		
BIRTHDATE	AGE	SEX F <input type="checkbox"/> M <input type="checkbox"/>	RACE (circle): American Indian/Alaska Native Hawaiian/Pacific Islander Other _____		Asian	Black/African American Caucasian	
CELL PHONE ()		HOME PHONE ()		WORK PHONE ()		ETHNICITY (Circle) Hispanic/Latino Unknown Other _____	
EMPLOYER NAME/ADDRESS				PHARMACY NAME, LOCATION, TELEPHONE #			
SPOUSE NAME				MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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 ()	<input type="checkbox"/> PATIENT NAME _____ <input type="checkbox"/> OTHER PHYSICIAN _____ <input type="checkbox"/> 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 <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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:

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REVIEW OF SYSTEMS

NAME _____ DOB _____ DATE _____

Please check those things which apply to you.

<p><u>Eyes</u></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/>Glasses <input type="checkbox"/>Contacts <input type="checkbox"/>Pain <input type="checkbox"/>Redness <input type="checkbox"/>Discharge <input type="checkbox"/>Tearing <input type="checkbox"/>Itching <input type="checkbox"/>Swelling <input type="checkbox"/>Light Sensitivity </div> <div style="width: 45%;"> <input type="checkbox"/>Floaters <input type="checkbox"/>Double Vision <input type="checkbox"/>Distortion <input type="checkbox"/>Loss of Color <input type="checkbox"/>NONE </div> </div>		
<p><u>Cardiovascular</u></p> <input type="checkbox"/> Chest pain/ Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Murmur <input type="checkbox"/> NONE	<p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Productive Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> NONE	<p><u>Musculoskeletal</u></p> <input type="checkbox"/> Muscle Cramps/ Spasm <input type="checkbox"/> Weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Aching Joints <input type="checkbox"/> Swelling Joints <input type="checkbox"/> NONE
<p><u>Gastrointestinal</u></p> <input type="checkbox"/> Special Diet <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Liver Disease <input type="checkbox"/> Diarrhea/ Constipation <input type="checkbox"/> Passing Blood <input type="checkbox"/> Change in Stool Color <input type="checkbox"/> NONE	<p><u>Genitourinary</u></p> <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Infections <input type="checkbox"/> Burning Urine <input type="checkbox"/> Genital Discharge <input type="checkbox"/> Dialysis <input type="checkbox"/> NONE	<p><u>Endocrine</u></p> <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Heat/ Cold Intolerance <input type="checkbox"/> Severe Thirst <input type="checkbox"/> Altered Menstrual Cycle <input type="checkbox"/> Infertility <input type="checkbox"/> NONE <input type="checkbox"/> HIV Positive
<p><u>Constitutional Problems</u></p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> NONE	<p><u>Skin and/ or Breast</u></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Change in Skin Color <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Breast Lumps/ Surgery <input type="checkbox"/> NONE	<p><u>Diabetes Controlled By</u></p> <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> NONE
<p><u>Ear/Nose/Mouth/ Throat</u></p> <input type="checkbox"/> Ringing Ears <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Difficulty Speaking <input type="checkbox"/> NONE	<p><u>Psychiatric</u></p> <input type="checkbox"/> Memory Loss <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Early Waking <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Attacks <input type="checkbox"/> NONE	<p><u>Neurological</u></p> <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches/ Migraines <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Numbness/ Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> NONE