

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 <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 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 <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
<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