2020

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:

____Blurry vision

____Hazy vision

____Glare

____Poor night vision

____Seeing in poor or dim light

____Halos

____Seeing rings or stars around lights

____Frequent changes in glasses

Have you noticed difficulty with your vision when you:

____Work at your job

____Manage your home

____Get around in your home

____Watch TV

____Use a computer

____Read newspapers

____Read the telephone book

____Read labels

____Read price tags

____Shop for groceries

____Drive during daylight hours

____Drive during evening/ night hours

____See traffic signs

____Sew or do crafts

____Play golf

____Enjoy recreation or leisure

____Recognize people

____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 PanOptix Trifocal lens (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.

Presbyopia Correcting Lens (Trifocal)

The Presbyopia Correcting 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.

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 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

Constitutional Problems

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

Cardiovascular

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

Endocrine

□Heat/ Cold Intolerance
□Severe Thirst
□Excessive Hunger
□Infertility
□NONE

Skin and/ or Breast

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

Ear/Nose/Mouth/ Throat

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

Gastrointestinal

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

Neurological

□Stroke
□Epilepsy
□Headaches/ Migraines
□Balance disturbances
□Numbness of extremities
□Tremors
□NONE

Musculoskeletal

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

Respiratory

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

Genitourinary

□Kidney Stone
□Infections
□Burning Urine
□Genital Discharge
□Dialysis
□Altered Menstrual Cycle
□NONE

Psychiatric

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

Diabetes Controlled By

□Diet
□Insulin
□Oral Medication
□NONE

□ HIV Positive
□ Cancer: _____
□ High Cholesterol
□ HIV Positive