ATHENS FAMILY VISION CLINIC

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Text? Y N

Email Address _____ Date of Birth _____ Age _____ Sex M F

Patient SS# _____ Patient DL# _____ Are you a student? Y N

Employer _____ Occupation _____

Are you married? Y N Spouse's Name _____ Are you currently pregnant? Y N

Medical Insurance _____ Member ID# _____ Group# _____

Policy Holder's Name _____ SS# _____ DOB: _____

Policy Holder's Address _____

Vision Insurance _____ Policy # _____

Policy Holder's Name _____ SS# _____ DOB: _____

Policy Holder's Address _____

*If a medical diagnosis is made at the time of your visit, your medical insurance will be billed in lieu of your vision insurance. This may result in additional specialist co-pay due at the time of exam.

Is today's visit for: GLASSES CONTACTS BOTH EMERGENCY MEDICAL

Do you currently wear: GLASSES CONTACTS BOTH

Hobbies _____

Preferred Language _____ Ethnicity _____

Date of Last exam _____ Where? _____

Primary Care Doctor's name _____ City _____

Preferred Pharmacy _____ Number _____

How did you hear about our office? _____

*If under 18 years of age, please complete the following information pertaining to the parent or legal guardian of minor:

Guardian Name _____ Relationship _____

Social Security # _____ DOB _____ Phone # _____

Please circle any of the following conditions that you ever been treated for or told that you have.

High blood pressure	High Cholesterol	Diabetes
Heart problems	Respiratory problems	Cancer
Thyroid Disease	Stroke	Headaches
Arthritis	HIV/ AIDS	Cataracts
Glaucoma	Floaters	Vision loss
Eye injury	Eye surgery	Double vision
Eye turn	Lazy eye	Allergies
Other: _____	Height: _____	Weight: _____

Family history of any of the conditions listed above? _____

Do you currently smoke? _____ How many per day? _____ How many years? _____

Do you currently drink? _____ How many per day? _____ How many years? _____

Known drug allergies: _____

Medications you are presently taking: _____

WARRANTY POLICY

We want you to love your new glasses! However, if you are not completely satisfied, we will gladly exchange your frame one time within 30 days of the receipt date. If your frame or lenses break within the first year from purchase date, we will replace the broken frame and/or lenses for a $20 warranty fee. Warranty does not apply to loss or theft. Any lenses or frame upgrades will require an additional cost. _____ (initials)

OUTSIDE PRESCRIPTIONS

We will gladly accept and make lenses from another doctor's office, however if you are not satisfied with the prescription, you will be responsible for 50% of the lens fees for a prescription change. _____ (initials)

CONTACT LENS POLICY

Open boxes are neither refundable nor returnable, unless the contact lenses were purchased from our office within the past year to date, and your prescription or brand has changed. To receive a prescription for contacts, you must have a yearly contact lens evaluation. This portion of the exam is not covered by insurance and is an out of pocket expense. The initial contact lens evaluation fee depends on the complexity of the fitting and will be determined after being examined by the doctor. The evaluation fee must be paid prior to receiving any contact lenses. _____(initials)

FINANCIAL POLICY

A 50% non-refundable deposit is required on all orders before orders can be completed.

The patient or guardian is responsible for all charges. If an insurance payment has not been received within 60 days from the date of service, the charges will become the responsibility of the patient. Personal accounts over 90 days past due will be turned over to Carter Young Collections (888) 995-4242 for collection procedures.

- **I authorize the use of this form for all my insurance submissions.**
- **I understand that Athens Family Vision Clinic will file my insurance as a courtesy for me and that for any reason my insurance company does not pay within a reasonable amount of time, or denies charges for any reason, I will be responsible for all charges.**
- **I authorize payment directly to Athens Family Vision Clinic.**
- **I have read and understand this financial policy.**

Signature of Patient/Guardian _____ **Date** _____

Athens Family Vision Clinic
270 Hawthorne Ave
Athens, GA 30606

Dr. Russell D. Springer, O.D.
Dr. Marsha Beckham, O.D.
Dr. Elisabeth Lawson, O.D.

If Athens Family Vision Clinic has a signed contract with my insurance company, provisions of the contract will be followed. Otherwise charges for the office visits are due at the time of service. Other procedures covered by insurance will be filed as a courtesy.

I understand I am responsible for seeing that all charges are paid in a timely manner. Deductibles, co-insurance, co-pays, non covered services, and all other balances not covered by insurance are my responsibility.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Athens Family Vision Clinic to disclose portions of my records or other privileged information necessary to process insurance on my behalf or to assist in my care. This includes the release of information to the referring physician, primary care physician, or facility involved in my medical care. I also hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and other health plans, to Athens Family Vision Clinic for unpaid charges.

I hereby acknowledge that I have been provided with a copy of Athens Family Vision Notice of Privacy Practices. The notice contains information regarding potential uses and disclosures of my protected health information that may be made by the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I choose.

____ I DO NOT authorize the release of my medical information to anyone.

____ I authorize the release of my medical information to the individual(s) listed below:

_____ (individual) _____ (DOB) _____ (relationship)

_____ (individual) _____ (DOB) _____ (relationship)

_____ _____ _____
Patient/Guardian Printed Name Patient/Guardian Signature Date

ADDITIONAL TESTING & PROCEDURES

As part of our detailed eye health and vision exam, we routinely recommend the use of Digital Retinal Imaging to establish a wellness baseline for new patients as well as to screen for potential retinal problems, arteriosclerosis, and hypertension. These conditions are progressive and can lead to partial loss of vision or blindness.

In addition to Digital Retinal Imaging, our Optometrists may feel it is necessary to request a Visual Field Test. This provides your doctor with a map of your visual field and assists in determining the location of vision loss. Visual field defects have a number of causes, including glaucoma, macular degeneration, multiple sclerosis, hyperthyroidism, pituitary gland disorders, high blood pressure, and diabetes.

Your doctor may find it necessary to perform an Optical Coherence Tomography (OCT) to check the progression of glaucoma and aid in the diagnosis of retinal conditions such as macular degeneration.

If you have underlying medical conditions (i.e. diabetes, high blood pressure, family history of ocular or systemic diseases) and our doctors find it necessary to perform one or more of these tests, we will bill your MEDICAL insurance. If your medical insurance denies the claim, applies the amount towards your deductible, or if you do not have medical insurance, you will be responsible for the charges.

CONTACT LENS POLICY AND EVALUATION FEES

To receive a prescription for contacts, you must have a yearly contact lens evaluation. The contact lens evaluation fee depends on the complexity of the fit and will be determined after by the doctor. This fee and must be paid at the time of service.

FINANCIAL POLICY

A 50% non-refundable deposit is required on all orders. The patient or guardian is responsible for all charges. If an insurance payment has not been received within 60 days from the date of service, the charges will become the responsibility of the patient. Personal accounts over 90 days past due will be turned over to Carter Young Collections Services (888) 995-4242 for collection procedures.

GLASSES PRICING & WARRANTY

All frames and lenses are covered under warranty for 1 year from the date of purchase. Frame warranty replacements are for frame defects or breakages occurring from normal wear and do not include damage from animals (chew/teeth marks). If your frame has broken under warranty, please DO NOT use superglue as this will void all warranties. There is a $20 charge for frame and lens warranty replacements.

Patient or Guardian Signature Date

Medical Insurance vs. Vision Insurance Billing 2019

When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, glaucoma, etc) it is necessary to file your visit with your medical insurance (BCBS, Aetna, Cigna, UHC, Medicare etc) instead of your routine vision exam insurance carrier (VSP, EyeMed, Davis, VBA, Always, Superior Vision, etc). The co-pays for your medical insurance will apply. Insurance carriers set these rules and our office is required to follow them. In many cases, depending on the chief complaint, there is no way to know prior to the examination which type of insurance our office will be able to file for you.

1. Many problems and complaints may attribute to a medical condition which requires a more in-depth investigation and additional medical decision-making to rule out any underlying eye disease. We will bill your MEDICAL insurance, NOT your routine VISION insurance plan. These include, but are not limited to:

- New or sudden blurry vision
- Flashes or floaters
- Dry or itchy eyes
- Eyestrain or double vision
- Eye pain
- Headaches
- Loss of vision
- Corneal abrasion
- Infection or conjunctivitis
- Over wearing of contacts

2. A variety of systemic conditions can profoundly and permanently affect a patient's vision that require a more in-depth investigation, which may include additional testing, follow up visits, and reports to your primary care physician. We will bill to your MEDICAL insurance, NOT your routine VISION insurance. These include, but are not limited to:

- Diabetes
- Hypertension
- Thyroid disease
- Lupus or autoimmune disease
- Diseases linked to high risk medications like Plaquenil

3. If you have been diagnosed by another eye doctor for any eye issues that require medical decision-making, treatment or management. We will bill your MEDICAL insurance, NOT your routine VISION insurance, These include, but are not limited to:

- Cataracts
- Amblyopic/lazy eye
- Glaucoma, previous diagnosis of high eye pressure or ocular hypertension
- Macular or retinal disease
- History of eye surgery

We strive to provide the best care, diagnosis, and treatment to you. We also make every effort to accept all MEDICAL insurance plans and file those claims for you. If you have any questions, please let us know.

I understand my Medical insurance will be filed if I have a medical problem, complaint, a medical condition, or a previous medical diagnosis. Routine vision insurance will be filed following guidelines set forth for by vision insurance carriers.

Signature: _____ **Date:** _____