Eye Consultants of Atlanta

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS

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770-422-4055
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Children's at Satellite Blvd Specialty Area
2660 Satellite Boulevard
Duluth, GA 30096
404-785-8630
404-255-2419 (appointments)

Children's at Forsyth Specialty Center
410 Peachtree Parkway
Suite 300
Cumming, GA 30041
404-785-3100
404-255-2419 (appointments)

Newnan
775 Poplar Road
Suite 105
Newnan, GA 30265
678-673-2340
678-673-2336 (fax)

General Office
Eye Consultants of Atlanta
3225 Cumberland Blvd, SE
Suite 900
Atlanta, GA 30339
404-351-2220

PLEASE PRINT **PATIENT** Male ☐ Female ☐ Age _____

PATIENT NAME _____
First Middle Last

BIRTHDATE ____/____/____ HOME PHONE _____ SS# _____

ADDRESS _____ CITY _____

STATE ____ ZIP _____ **REFERRING DOCTOR** _____

MOTHER'S NAME _____ BIRTHDATE _____

CELL PHONE _____ EMAIL ADDRESS _____

FATHER'S NAME _____ BIRTHDATE _____

CELL PHONE _____ EMAIL ADDRESS _____

LEGAL GUARDIAN(S) MOTHER ☐ FATHER ☐ OTHER ☐ _____

EMERGENCY CONTACT _____ PHONE _____

INSURANCE

PRIMARY INSURANCE _____

POLICY HOLDER _____ SS # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____

SECONDARY INSURANCE
_____

POLICY HOLDER _____ SS # _____

ADDRESS _____

CITY _____ STATE ____ ZIP _____

EMPLOYED BY _____

**IMPORTANT: PLEASE PRESENT INSURANCE CARDS WITH THIS COMPLETED FORM*

Your signature below authorizes us to release information and receive payment from your insurance company for those services received from the physician and the assisting physician.

Signed _____ Date _____

Date:	Chart #	Patient Name:

This Authorization Remains in Effect Unless Revoked by me in Writing:

1) I hereby authorize **EYE CONSULTANTS OF ATLANTA, PC**, hereinafter referred to as "ECA", to provide information concerning any treatment rendered to me, or to any member of my family, to: a) my insurance carrier(s); b) any physician who referred me to "ECA"; and c) any medical practitioner "ECA" physicians may refer me (them) to for further medical or therapy treatment.
2) I authorize the release of any medical information, including confidential information related to psychiatric care, drug and alcohol abuse, and HIV / AIDS treatments, necessary to process insurance claims or required for utilization review or quality assurance activities.
3) I further authorize "ECA" to utilize any modern form of transferring this documentation - including, but not limited to, the US Mail, Federal Express, tele-facsimiles (faxes), couriers or similar methods - to its requested destination.
4) I hereby assign to "ECA" all applicable payments to be received from my insurance carrier(s) for medical services rendered. I further authorize the transfer of funds, for credit balances on my accounts, between "ECA" and Piedmont Eye, LLC, for any and all outstanding account balances that may reside in either entity, and I understand that any remaining credit balance shall be refunded directly to me.
5) I hereby agree that *I am personally responsible* for ensuring that all charges for services rendered are paid by either myself or my insurance carrier(s).

⇨ **X** _____ **X** _____

Patient's Signature (Parent or Guardian, if minor) Relationship to Patient

PATIENTS UNDER 18 YEARS OF AGE MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN. THIS IS REQUIRED BY LAW AND SERVES TO PROTECT YOU AND YOUR CHILD.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf , to "ECA" for any services furnished to me by those physicians. I authorize any holder of medical information to release to the Health Care Financing Administration, ie., Medicare, and its agents, any information needed to determine those benefits or the benefits payable for related services.

⇨ **X** _____ _____ _____

Patient's Signature **Medicare Number** **Date of Signature**

EYE CONSULTANTS OF ATLANTA FINANCIAL POLICY LETTER

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Refractions (the part of the examination to test your vision for glasses) and routine eye examinations usually are not covered services on medical insurance plans. Therefore, **payment is expected at the time of service.**
2. It is your responsibility to provide us with your current address, telephone number, email address an insurance information **at each visit.**
3. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant of your plan. **If you see a doctor that is not currently on your plan, you will be responsible for payment in full.**
4. All co-payments are due at the time of service. A $75 service fee will be charged for failure to pay the co-payment at the time of service.
5. If you are unable to keep your scheduled appointment, there will be a $50 charge. We must receive notification of this change no later than 24 hours from the scheduled appointment.
6. Medicare Recipients: We are a participating Medicare practice and thus, will file your Medicare claim. If you have supplemental coverage, we will also file only one supplemental plan. **During the month of January, it is our policy to collect in full your Medicare deductible and the 20% co-payment at the time of service.** This holds true regardless of the availability of supplemental coverage or payment of your deductible to non-ECA physicians or providers.
7. If you are experiencing personal circumstances that will make payment of our charges difficult for you, please contact one of our Patient Account Representatives at 404-351-2220.
8. **Medicare does not cover the refraction (the part of the examination to test your vision for glasses). Therefore, the fee of $60 is your responsibility in addition to the 20% co-payment.**
9. We will mail you a monthly statement for any outstanding balances. If the claim has not been paid by your insurance carrier within 30 days of the date of service, please contact your carrier and assist us in getting your claim paid.

I acknowledge that I understand and accept this financial policy.

Signature: _____ Date: _____

(For your convenience, we accept cash, personal checks, Visa, MasterCard, American Express and Discover)

Notice of Privacy Practices Acknowledgment of Receipt
Eye Consultants of Atlanta, P.C.

Patient Acknowledgment Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By signing below, you acknowledge that you have received a copy of the Notice of Privacy Practices.

As stated in our Notice of Privacy Practices, we will use and disclose your health information for treatment, payment and health care operations, as well as other purposes stated in the Notice. By consenting to treatment and accepting financial responsibility for your treatment, you agree and acknowledge that from time to time we will communicate with you about your treatment, payment and related issues using the means of communication that you have furnished to us, including your e-mail and cell phone number. We may call and/or text your cell number or e-mail you with treatment and related information, such as appointment confirmations and reminders, annual visits and wellness check-ups, pre-operative instructions, prescription notifications, payment reminders, to recommend treatment options or alternatives or follow-up items or services. In addition, we may share with you certain health-related items or services that may be of interest to you. It is the policy of Eye Consultants of Atlanta that you may opt-out of e-mail or cell/text communications at any time.

_____	_____
Patient's Name: (Print) Date	Date
_____	_____
Person authorized to sign for Patient	Relationship to Patient:

Eye Consultants of Atlanta
THE PIEDMONT EYE GROUP

OPTIONAL

Patient name: _____

Patient date of birth: _____

Preferred language: _____

Race ◯ **Decline to specify**

- ◯ White
- ◯ Black or African American
- ◯ American Indian or Alaskan Native
- ◯ Other
- ◯ Asian
- ◯ Caucasian
- ◯ Naive Hawaiian or Other Pacific Islander

Ethnicity ◯ **Decline to specify**

- ◯ Unknown / Not Reported
- ◯ Not Hispanic or Latino
- ◯ Hispanic or Latino

CMS (Medicare) and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must use in order to be compliant with government regulations.

EYE CONSULTANTS OF ATLANTA COVID Disclaimer

I understand that Eye Consultants of Atlanta, its doctors, nurses, and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent. By checking this box below, I agree that I will not hold Eye Consultants of Atlanta or any of its doctors, nurses, staff or facilities personally responsible should I, or someone I come in contact with, become positively or presumptively positively diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Eye Consultants of Atlanta and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision and eyesight.

☐ I understand and agree to the COVID disclaimer.

_____ _____

Patient's Name Date