Eye Physicians & Surgeons of Augusta, P.C.
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Patient Information

Date	Incoming Complaint (What problems are you having with your eyes?)

Patient Information

Name (Last, First, MI)		Gender	Mr. Mrs. Ms. Dr. Other:		Date of Birth
Mailing Address - Street	City	State	Zip	Race	Mother's Maiden Name

Home Phone	Day Time Phone	Cell Phone

E-mail address

Social Security Number	Marital Status	Primary Language	Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Unknown

Responsible Party Information ☐ Same as Patient

Name (Last, First, MI)			Mr. Mrs. Ms. Dr. Other:
Date of Birth	Social Security Number	Relationship	

Address - Street	City	State	Zip

Home Phone	Day Time Phone	Cell Phone

Primary Insurance Information

Policy Holders Name (Last, First, MI)	Date of Birth	Relationship to Patient

Insurance Company	Policy Number	Group Number

Secondary Insurance Information

Policy Holders Name (Last, First, MI)	Date of Birth	Relationship to Patient

Insurance Company	Policy Number	Group Number

Treatment Consent

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partners, associates, and consultants. My presence at each future appointment implies and confirms my ongoing consent for treatment.

Patient/Responsible Party Signature

Eye Physicians & Surgeons of Augusta, PC

Patient Financial Policy

We are committed to providing you with the best possible care, and will work with you to meet any special needs you might have. However, that requires that both the patient and physician understand what is expected of the other, medically and financially.

The following information is an agreement between Eye Physicians & Surgeons of Augusta and Patient/Responsible Party named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

Insurance Participation

Our office participates in a variety of insurance plans and networks, and we will submit claims to those carriers that we participate with. However, there are several points we wish to emphasize:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- Failure to provide our office with the correct insurance information may result in claims being denied and balances due being transferred to patient responsibility. It is imperative that you provide accurate and current information.
- We will file major medical insurance but we do not participate with any vision plans.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- You are expected to pay your copayment/coinsurance at each visit.
- If we do not participate with your insurance plan/network, you will likely have a higher out-of-pocket expense, so please be prepared.

Non-Covered Services/Refractions

Refractions are non-covered services that are routinely a part of your eye exam. Please understand that if you decline the Refraction we will be unable to prescribe new glasses for you or prescribe a change in your existing glasses since the Refraction is the test necessary to determine your glasses prescription. We will also lose the ability to evaluate your best correctable vision in order to rule out decreased vision that may be caused by a medical condition. The Refraction is never covered service by Medicare and rarely covered by Private insurances.

Past Due Accounts

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency. All fees assessed by the agency will be charged to you and become part of your outstanding balance. If your account is forwarded to an outside collection agency, your relationship with this practice will be terminated.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THESE POLICIES.

Name: _____ Date: _____
Print Name of Patient

Signature: _____ _____
Signature of Patient or Responsible Party Relationship to Patient

REFRACTION POLICY

A “refraction” is the work performed by one of our certified technicians and/or physicians to determine your glasses/contact lens prescription. The fee for this diagnostic test is $40.00 and will be collected from you at your office visit if you are given a glasses/contact lens prescription.

We will bill your insurance company for the refraction fee and if we receive payment, we will promptly issue a refund for the resulting overpayment.

If you choose not to get your glasses/contact lens prescription at your office visit, the refraction fee will be waived. However, if you call back within 90 days to get your glasses/contact lens prescription, the refraction fee will be reinstated. If you call back after 90 days, you will need to come back into the office and have another refraction done.