Bradley A. Bertram, M.D. FACS
Bruce A. Brown, M.D.
Herbert P. Fechter, M.D.
Beau Gardner, M.D.
Ryan T. Smith, M.D.

www.eyeguys.com

James Lockwood, M.D.
Douglas W. Ellenberger, O.D.
Robert R. Morgan, O.D.
Kyle Fluharty, O.D.
Harika Karunakota, O.D.

| PATIENT INFORMATION ( PLEASE PRINT ) | | | | |
|---|---|---|---|---|
| Name (Last, First, MI ) | | Gender | Mr. Mrs. Ms. Dr. | Date of Birth |
| Mailing Address-Street | City | State | Zip | Race |
| Home Phone | Cell Phone | | Preferred Phone ( Circle One ) Cell Home | |
| E-mail address | | | | |
| Social Security Number | Marital Status (Circle One) S M W D | Primary Language | Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Unknown | |
| Emergency Contact Name/ Relationship | | Emergency Contact Numbers | | |

| RESPONSIBLE PARTY INFORMATION IF OTHER THAN SELF ( PLEASE PRINT ) | | | |
|---|---|---|---|
| Name (Last, First, MI ) | | | Mr. Mrs. Ms. Dr. |
| Date of Birth | Social Security Number | Relationship | |
| Mailing Address-Street | City | State | Zip |

**ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT**

**Authorization / Consent for Examination and Treatment**

I hereby agree and give consent to the treating physician and employees of this office and any affiliations; Eye Physicians and Surgeons of Augusta; Eye Surgery Center of Augusta; Eye Guys Specs Vision Center; hereafter called Eye Guys; 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 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. I understand no guarantee or assurance has been made as to the results that may be obtained.

**Assignment of Benefits**

I hereby assign and authorize my insurance carrier or other benefits plan including Medicare, other government sponsored insurances and benefits of which I may be covered and/or all commercial payers to make payments on my behalf directly to Eye Guys for services rendered. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. I authorize Eye Guys to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Guys accepts the charge determination of the Medicare carrier as the full charge. I am responsible for the deductible, coinsurance and noncovered services.

**Financial Responsibility**

I understand that payment is due at the time of service. I understand that all charges for services rendered at Eye Guys are ultimately the responsibility of the patient. Eye Guys will file claims with most insurance and benefit plans, however, once the claim has been processed, all co-insurance, any remaining copay, deductible amounts as well as fees for any service rendered, but not covered by my insurance policy are due upon receipt of the billing statement. I will receive a statement from Eye Guys for such fees not paid at the time of service. I further agree that, if permissible by law, I will reimburse Eye Guys for all costs, expenses, attorney fees that may be incurred in attempts to collect those charges.

**Authorization to Release Information:**

I hereby authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or my child/children for services rendered.

***I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.***

_____ _____ _____

Patient/ Responsible Party Signature | Relationship to Patient | Date

www.eyeguys.com
Augusta Location: 1330 Interstate Parkway, Augusta, GA 30909
Aiken Location: 792 Silver Bluff Road, Aiken, SC, 29803

# Eye Guys Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best quality care possible and will work with you to meet any special needs you may have. The following information is an agreement between Eye Guys and you, the Patient or Responsible Party. By signing this agreement you acknowledge receipt of our financial policy and agree to pay for all services received.

**Payment Due at Time of Service:** In order to provide you with high quality care at a reasonable cost, we must require payment of any co-pay, deductible, and non-covered service at the time services are rendered. If you are unable to pay at the time of service we will gladly reschedule your appointment. We accept Cash, Check, Credit Card, and Care Credit. When you present us with a check you are authorizing us to convert it to an electronic check.

**Insurance Participation:** Our office participates with a variety of insurance plans and networks, and we will gladly submit claims to those carriers with which we participate and act as your advocate in an effort to get your claim paid. However, you are ultimately responsible for all charges. We do not participate with vision insurance. It is your responsibility to provide us with all current health insurance information. The following outlines our insurance participation policies:

- Your insurance policy is a contract between you and your 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.
- You must bring your insurance card with you to every visit and make us aware of any changes in coverage in a timely manner.
- Failure to provide our office with the correct insurance information may result in claims being denied and balances being transferred to patient responsibility. It is imperative that you provide complete, accurate and current information in a timely manner.
- You are expected to pay your co-pay, deductible and/or coinsurance at each visit. In order to comply with the participation agreement we have with your insurance company, we must collect any co-pay and/or deductible amount at the time of service.
- It is your responsibility to know if we participate with your insurance plan or not prior to services being rendered. If we do not participate with your insurance plan you will likely have a higher out-of-pocket expense.
- If you have a high deductible plan we reserve the right to collect payment in full at the time of service.
- If you are seen after-hours or on weekends you may be assessed an after-hours charge. We will file this charge to your insurance, however, the claim is likely to be denied as a non-covered service making the balance your responsibility.
- In order to protect your identity and file your insurance claim, we will keep your photo ID scanned into your chart **OR** we will require you to present a photo ID at each visit so we can confirm your identity.

**Uninsured Patients:** If you do not have insurance, payment is required in full at the time of check in.

**Past Due Accounts and Returned Checks:** If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency. If your account is forwarded to an outside collection agency, your relationship with this practice will be terminated. All fees assessed by the collection agency will be charged to you and become part of your outstanding balance. Returned checks are subject to a $25 processing fee. The amount of the returned check plus the processing fee must be paid by cash, money order or credit card within 10 days of receipt of written notification from our office. We require you to provide your social security

number, which will be kept private and confidential, and used for collection purposes only. If you refuse to provide your social security number then payment is required in full at the time of check in.

**Missed/No Show Appointments:** When you miss or "No Show" for an appointment you deny valuable time to another patient in need of medical care. We realize that unexpected circumstances may arise but we ask that you call at least 24 hours in advance to cancel or reschedule your appointment if possible. It is our policy to charge a No Show fee of $25 for missed or cancelled appointments without 24 hours notice. We will waive this fee for the first "No Show" appointment.

**Minor Patients:** If the patient is a minor (anyone younger than 18 in GA / 17 in SC), a parent or guardian MUST be present at the appointment. If a parent or guardian cannot be present we will gladly reschedule the appointment.

**Refractions:** The refraction is the diagnostic portion of the eye exam which determines whether your vision can be improved with glasses or contact lenses. It is a non-covered service by Medicare and is rarely covered by Private insurance. These plans consider a refraction to be a vision service and not a medical service. Therefore, you are responsible for payment of the refraction at the time of service. We will bill your insurance plan for this diagnostic test and refund you in the event your insurance plan pays the claim.

**Surgical Appointments and Fees:** There are several steps involved in preparing for your surgery so it is important that you keep your scheduled surgery appointment in order to complete your treatment as planned. It is important that we are able to contact you about any questions or changes regarding your planned surgery. It is your responsibility to contact our office as soon as possible if there is a change in your contact information. If we are unable to contact you in a timely manner your surgery may be cancelled. It is also your responsibility to advise us if there is a change in your insurance. We will verify insurance benefits prior to the date of your surgery. Payment in full is required prior to elective procedures. A cash discount is offered to patients who are not insured.

Thank you again for choosing our office. If you have any questions concerning the above financial policy, please ask to speak to one of our benefits counselors.

**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

Augusta Location: 1330 Interstate Parkway, Augusta, GA 30909
Aiken Location: 792 Silver Bluff Road, Aiken, SC, 29803

# PATIENT ACKNOWLEDGEMENT AND HIPAA CONSENT

I hereby acknowledge that Eye Guys has provided me with access to its Notice of Privacy Practices, as is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I further acknowledge that Eye Guys has offered to me and will, upon my request, provide me with a hard copy of its Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

| Date | Patient Name | Date of Birth |
|---|---|---|

## The physician/practice may use or disclose the following protected health information:

Entire Medical Record: ☐ YES ☐ NO

If NO, then the following protected health information can be released: _____

**Release of Protected Health Information**: List the full name(s) of those with whom we are authorized to discuss and /or release details concerning your medical records / financial information:

| Print Name | Relationship to Patient | Phone Number |
|---|---|---|
| | | |
| Print Name | Relationship to Patient | Phone Number |
| | | |
| Print Name | Relationship to Patient | Phone Number |

*If not the patient, please describe the representative's authority to act on behalf of the patient:*

- ☐ *The representative is the parent or legal guardian of the patient, who is a minor.*
- ☐ *The representative is the guardian of the patient, who has been adjudicated incompetent.*
- ☐ *The representative is acting under a Durable Power of Attorney for Health Care or Advance Directive for the patient, and has presented a copy of this document to personnel.*

***Please attach the Power of Attorney to this document.***

I give permission to leave detailed voice messages on this cell phone:_____

I give permission to leave detailed voice messages on this home phone:_____

| Patient / Representative Signature | Print Representative Name | Date |
|---|---|---|