VIDALIA EYECARE CENTER

PLEASE PRINT **TODAY'S DATE**

Patient's Name_____ **Sex**_____ **Race** _____ **DOB** _____

Address_____ **SS #** ____/____/_____

City/State _____ **Zip** _____**Home PH#** _____ **Cell PH #** _____

Marital Status: M W S D

Employer _____ **Title** _____

FT _____/ **PT** _____ **Employers Address** _____ **Work Ph #** _____

Primary Care Physician _____

Pharmacy/Pharmacies Used for Prescriptions _____ **Phone #** _____

Patent or legal Guardian of minor child _____

INSURANCE INFORMATION: (Please give copy of Insurance cards to receptionist)

Insurance Name _____

Policy # _____ **Group #** _____

Policy's Holder's Name _____ **DOB** _____

Policy's Holder's Address _____ **SS #** _____/ _____/_____

City/State _____ **Zip** _____ **Home PH #** _____ **Cell PH #** _____

Policy's Holder's Employer _____

Person Responsible for Charges _____ **Relationship to Patient** _____

Address _____ **Phone #** _____

Were you referred here by someone? _____ If YES, Whom? _____

Has anyone in your family been here before? _____ If YES, Whom? _____

Reason for Today's visit: _____

INSURANCE RELEASE INFORMATION

I AUTHORIZE VIDALIA EYECARE CENTER TO RELEASE ANY NECESSARY MEDICAL INFORMATION TO MY INSURANCE CARRIER THAT MAY BE NEEDED TO PROCESS ANY CLAIMS FOR ANY DATE OF SERVICE,

SIGNATURE _____

ALL CHARGES, CO-PAYS, AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

MEDICAL HISTORY QUESTIONNAIRE

List any medications you currently take (Prescription, Vitamins and Over the Counter): _____

_____

_____

_____

List all major illnesses: (glaucoma, diabetes, high blood pressure, heart attack, etc.) or Injuries (concussion etc.) ____

_____

_____

_____

_____

List any surgeries you have had: (cataract, tonsillectomy, appendectomy, etc.) _____

_____

_____

_____

Are you Allergic to any Medications? (Circle one) YES or NO If YES list the Medication: _____

_____

_____

Do you have any Non-Medication related Allergies: (latex, food, etc.)

_____

_____

_____

PLEASE CIRCLE YES OR NO:

Do you drive? **YES** **NO**
Do you have visual difficulty when driving? **YES** **NO**
In the past have you ever worn contact lenses? **YES** **NO**
Do you currently wear contact lenses? **YES** **NO**
If YES, How long? _____ **What Brand do you currently wear?** _____
Monthly _____ **Dailies** _____ **Bi-Weekly** _____

Do you currently wear glasses? **YES** **NO**
If YES, How Long? _____

Date of last eye exam? _____

Do you drink alcohol? **YES** **NO**
Occasional **1 per day** **2-3 per day** **4+ per day**
Do you Smoke? **YES** **NO**
Occasional **1 per day** **2-3 per day** **4+ per day**
Have you ever had a blood transfusion? **YES** **NO**

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF "YES" PLEASE PROVIDE INFORMATION

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision (halos)			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/Watering			
Glare/Light Sensitivity			
Eye Pain or Soreness			
Infection of Eye or Lid (Blepharitis, Stye)			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Drooping Eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EAR, NOSE, THROAT (Sinus, Ear Infection, Chronic Cough, Dry Month, etc.)			
CARDIOVASCULAR (Heart Vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTIONAL (Stomach, Ulcers, Intestinal Diseases, etc.)			
GENTITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, Warts, Skin Cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia, etc.)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, Anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			
GLAUCOMA, RETINAL DISEASE			
CATARACT			

IF "NO" PLEASE MARK "NO". PLEASE DO NOT LEAVE ANY SPACES EMPTY.

FAMILY HISTORY

M=mother F=father S=sister B=bother GP=grandparents (please mark)

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

GENERAL INFORMATION

Vidalia Eyecare offers a full range of services to help our clients to see their best. Your eyes can be an indicator of your overall health and annual exams are a way to ensure the health of your eyes, as well as provide information about other health issues you may be experiencing. We off comprehensive exams to check all aspects of your eye health. There are two ways that we can check the health of the eye and that is with Dilation & Optos.

Dilation: is the opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. Dilation is strongly recommended for patients with a history of cataracts, high blood pressure, Diabetes, Glaucoma, High prescriptions, and patients older than 40. After being dilated, you may experience blurred near vision and light sensitivity. These side effects can last from 3-6 hours.

Optos: is our new device that gives the doctor the same panoramic view of the back of the eye without the use of drops. No blurry vision/light sensitivity after your exam. Optos device allows our doctor to examine 82% of your retina without dilating eyes in just one image. This view enhances our doctor's ability to detect any problems or diseases of the eye, such as diabetic retinopathy, age-related macular degeneration, glaucoma and more. There is a fee of $40.00 for Optos due at the time of check -out.

All charges, co-pays, and deductibles are due at the time the services are rendered, unless other arrangements have been made prior to appointment.

If you need to cancel or reschedule an appt please call 24 hours in advance and we will be glad to assist you with that.

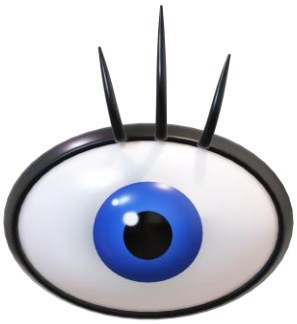
Please keep cell phone use at a minimum in waiting room, exam rooms and while being fitted for glasses. If you need to use your cell phone, as a courtesy to others, PLEASE STEP OUTSIDE.

We hope you enjoy your visit at Vidalia Eyecare, LLC. Thank you for your business.
I have read and answered this form accurately and to the best of my ability.

Signature: _____ Date: _____/ _____/ _____

1. **MEDICARE**: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENFITS BE MADE ON MY BEHALF TO VIDALIA EYECARE CENTER FOR SERVICES FURNISHED FOR ME BY VIDALIA EYECARE CENTER. I AUTHORIZE ANY HOLDER OF 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 MEDCIAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDOCATED IN ITEM 9 OF THE INFORMATION TO THE INSURER OF AGENCY SHOWN. VIDALIA EYECARE CENTER ACCEPTS THE CHARGE DETERMNATION FO MEDICARE CARRIER AS THE FULL CHARGE, AND I AM RESPONSIBLE ONLY FOR THE DEBUCTIBLE DETERMINATION OF THE MEDICARE CARRIER. _____ INITIAL
2. **MEDIGAP**: I UNDERSTAND THAT IF A MEDIGAP POLICY OR OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE HCFA 1500 FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. I REQUEST THAT PAYMENT OF AUTHORIZED SECONDARY INSURANCE BENEFITS BE MADE ON MY BEHALF TO VIDALIA EYECARE CENTER, IF POSSIBLE OR OTHERWISE TO ME. _____ INITIAL
3. **RELEASE OF INFORMATION**: **VIDALIA EYECARE CENTER** MAY DISCLOSE ALL OR PART OF MY MEDICAL RECORD AND/OR FINANCIAL LEDGER, INCLUDING INFORMATION REFUARDING ALCOHOL OR DRUG ABUSE, PHYCHATIC ILLNESS, COMMUNICABLE DISEASE, OR HIV, TO ANY PERSON OR CORPORATION (1) WHICH IS OR MAY BE LIABLE OR UNDER CONTRACT OT VIDALIA EYECARE CENTER FOR REIMBURSEMENT FOR SERVICES RENDERED, AND (2) ANY HEALTH CARE PROVIDER FOR CONTINUED PATIENT CARE. VIDALIA EYECARE CENTER MAY ALSO DISCLOSE ON AN ANONYMOUS BASIS ANY INFORMATION CONCERNING MY CASE, WHICH IS NECESSARY OR APPROPRIATE FOR THE ADVANCEMENT OF MEDICAL SCIENCE, MEDICAL EDUCATION, MEDICAL RESEARCH, FOR THE COLLECTION OF STATISTICAL DATA, OR PURSUANT TO STATE OR FEDERAL LAW, STATURE, OR REFULATION. A COPY OF THIS AUTHORIZATION MAYBE USED IN PLACE OF THE ORGINAL. _____ INITIAL
4. **OTHER INSURANCE**: I UNDERSTAND THAT VIDALIA EYECARE CENTER MAINTAINS A LIST OF HEALTH CARE SERVICE PLANS WHICH IT CONTRACTS. A LIST OF SUCH PLANS IS AVAILABLE FROM THE BUSINESS OFFICE, AND VIDALIA EYECARE HAS NO CONTACT, EXPRESSED OR IMPLIED, WITH ANY PLAN THAT DOES NOT APPEAR ON THE LIST. THE UNDERSIGNED ADREES THAT I AM INDIVIDUALLY OBLIGATED TO PAY THE FULL CHARGED OF ALL SERVICES RENEDERED TO ME BY VIDALIA EYECARE CENTER. IF I BELONG TO A PLAN THAT DOES NOT APPEAR ON THE ABOVE MENTIONED LIST. _____ INITIAL
5. **NON-COVERED SERVICES**: I UNDERSTAND THAT VIDALIA EYECARE CENTER CONTRACTS WITH HEALTHCARE SERVICES PLANS (I.E HMOS,PPOS) STATE ITEMS AND SERVICES WHICH ARE "COVERED" BY THE HEALTH CARE SERVICES PLANS, ASSORDINGLY, THE UNDERSIGNED ACCEPTS FULL FINANCIAL RESPONSIBILITY FOR ALL ITEMS OR SERVICES, WHICH ARE DETERMINED BY THE HEALTH CARE SERVICES PLANS NOT COVERED, EXAMPLES OF NON-COVERED SERVICES INCLUDE, BUT ARE NOT LIMITED TO, SERVICES NOT SPECIFIED AS BEING COVERED IN THE SERVICES PLAN FURNISHES TO THE PATIENT: AND TREATMENT OR TESTS NOT AUTHORIZED BY THE HEALTH CARE SERVICES PLAN. THE UNDERSIGNED AGREES TO COOPERATE WITH VIDALIA EYECARE CENTER TO OBTAIN NECESSARY CARE SERVICES PLAN AUTHORIZATIONS. _____ INITIAL
6. **FINANCIAL AGREEMENT**: I AGREE THAT IN RETURN FOR THE SERVICES PROVIDED TO THE PATIENT BY VIDALIA EYECARE CENTER, I WILL PAY MY ACCOUNT AT THE TIME SERVICE IS RENDERED OR WILL MAKE FINANCIAL ARRANGEMENTS SATISFACTORY TO VIDALIA EYECARE CENTER FOR PAYMENT. IF AN ACCOUNT IS SENT TO AN ATTORNEY FOR COLLECTION, I AGREE TO PAY COLLECTION EXPENSES AND REASONABLE ATTORNEY'S FEES AS ESTABLISHED BY THE COURT AND NOT BY A JURY IN ANY COURT ACTION. I UNDERSTAND AND AGREE THAT IF MY ACCOUNT IS DELIQUENT, I MAYBE CHARGED INTEREST AT THE LEGAL RATE, ANY BENEFITS OF ANY TYPE UNDER ANY POLICY OF INSURANCE INSURING THE PATIENT OR ANY OTHER PARTY LIABLE TO THE PATIENT, IS HEREBY ASSIGNED TO VIDALIA EYECARE CENTER. IF COPAYMENTS AND/OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO VIDALIA EYECARE CENTER. HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND/OR THE PATIENT ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL. _____INITIAL

SIGNATURE: _____ **DATE**: _____/ _____/ _____



Cancelation and "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Vidalia Eyecare LLC reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for understanding and your cooperation as we strive to best serve the needs of all our patients.

Patient or Legal guardian signature:

_____

Date:

_____

VIDALIA EYECARE
206 MAPLE DR
VIDALIA, GA 30474

INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

NAME: _____ DOB: _____/ _____/ _____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

( ) SPOUSE _____

( ) CHILD(REN) _____

( ) OTHER _____

( ) INFORMATION IS NOT TO BE RELEASED TO ANYONE.

THE RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

SIGNED: _____ DATE: _____/ _____/ _____

SIGNED: _____ DATE: _____/ _____/ _____

VIDALIA EYECARE

206 MAPLE DRIVE

VIDALIA, GA 30474

EYEGLASS WARRANTIES & DISCLAIMERS

Eyeglasses are custom order prescription medical devices and are, therefore, non-refundable. Please be sure to review your order carefully with our Optician before signing the order form and making your payment.

Warranted frames have a one year, one time replacement or repair against DEFECTS in the frame or normal wear and tear and are covered by manufacturers, at their discretion. Not all frames are warranted, be sure to ask if you have any concerns.

Non-warranted frames are sold as is, however, we will make every attempt to repair or replace the frame, if necessary, due to frame defect one time during the first 30 days after receipt of your completed glasses.

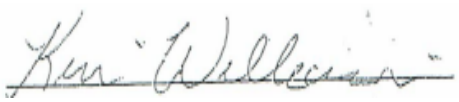
On occasion, a patient may need to change frames after an order has been placed. If this should occur, a restocking fee will apply. There are limitations and there may be additional charges, please discuss this with the Optician.

If you feel that the prescription is not correct, please feel free to schedule a time to come in and discuss your problem with our Optician and the Doctor. If it is necessary, we will re-examine you at no charge within the first 30 days of receipt of your glasses. A charge of $65 may be applied if we re-check your prescription at a later date.

If you are unable to adapt to your progressive lens within the first 30 days, we can discuss options and remake the lenses for you. There may be additional fees associated with this process.

Although we always exercise the greatest of care, we are not responsible for the patient's own frame should it break while we are adjusting, repairing or reusing it for a new prescription. This includes new frames purchased elsewhere and brought to us and non-prescription sunglasses.

Please remember- ALL EYEGLASSES ARE CUSTOM MADE. SORRY, NO REFUNDS.



Optician Signature

_____

Patient Signature