ATHENS RETINA CENTER

COMMUNITY DRIVEN | COMPASSIONATE CARE

2705 Jefferson Road, Athens, GA 30607

To prepare for your upcoming visit to Athens Retina Center, here is a list of helpful suggestions.

1. **Please be prepared to spend 2-4 hours for your initial appointment.**
    - **This visit includes a detailed history, comprehensive eye and retinal examination, additional testing as needed, discussion of your diagnosis and treatment plan with your doctor, and initial treatment if needed.**
2. **Your eyes will be dilated (eye drops to enlarge your pupil) for your retina to be examined.**
    - **While the dilation wears off after several hours, your vision may be blurred and your eyes may be light sensitive after your visit. It's best to have someone to drive you after your initial appointment. For subsequent appointments, you can judge whether or not you need a driver.**
3. **Please bring to your appointment:**
    - **"New Patient" forms completed before arriving**
    - **Your current eyeglasses or contacts**
    - **A list of your medications, including eye drops and vitamins.**
    - **List and dates of past medical issues and surgical procedures**
    - **List of doctors you are seeing and the referring doctor's name**
    - **A copy of your insurance card and a photo ID, such as a driver's license.**
    - **Copay payment due at time of service <u>OR</u> $750 initial deposit for non-insured patients due at check-in by cash or credit card only.**

If you have any questions, please call our office at 706-543-3200

ATHENS RETINA CENTER

PATIENT INFORMATION
PLEASE BRING AND PROVIDE **COMPLETE** INFORMATION FOR EACH ITEM.

(LEGAL) FIRST NAME ________________________________ **MI** ______ **LAST** ______________________________________

LOCAL ADDRESS ___________________________________ **CITY** __________________ **STATE** _____ **ZIP** ___________

PHONE # (____) ____-_____ CELL (____) _____-______ WORK PHONE (____) _____-______

DATE OF BIRTH ______ -_____-_______ SEX ___ SOCIAL SECURITY#______-______-_____ MARITAL STATUS: S M W D

RACE: ______________ **ETHNICITY: (Please circle) Hispanic or Latino Non- Hispanic or Latino Other**

EMAIL ADDRESS: ________________________________ **PREFERRED LANGUAGE:** _________________________

PRIMARY INSURANCE HOLDER _______________________________ **SS# ____-____-____ Date of Birth ____-____-_____**

REFERRED BY

NAME: ____ **(OD MD DO) PHONE: _______-_________-________**

ADDRESS: ______________________________________ **CITY** _________________ **STATE** _______ **ZIP** ________________

FAMILY PHYSICIAN __________________________________ (MD ,OD) PHONE # ______-______-________
ADDRESS ____ CITY ____________________ STATE ____ ZIP _______

EMERGENCY CONTACT : __________________________________ PHONE: (____) -______-________

RELATIONSHIP TO PATIENT: ____

$750 Deposit due at Check-In for Non-Insured Patients Cash _______ Credit Card ____ Amount Paid: _______
Patient Signature: ____________________________________ Date: ___________________________________

IF PATIENT IS A MINOR OR DEPENDENT

NAME OF RESPONSIBLE PARTY: ________________________________ RELATIONSHIP TO PATIENT: ___________

RESPONSIBLE PARTY ADDRESS: ___________________________________ Date of Birth _____-_______-_________

CITY: ___________________________ STATE ______ ZIP: ______________ PHONE: (______) _______-_______________

ACCIDENT RELATED (CIRCLE) WORK AUTO OTHER ____________________________________

WHAT HAPPENED? ____
PERSON TO CONTACT ____ PHONE (_____) ______-________

PATIENT NAME: ____ **DATE:** ________________________

OCULAR HISTORY: ____

Current problem with vision: ____

Past eye problems and surgeries: ____

Current eye medication: ____

PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)

RT	**LT**	Lazy Eye since birth	**RT**	**LT**	Burning
RT	**LT**	Eye glasses worn @childhood	**RT**	**LT**	Bulging forward
		@adulthood	**RT**	**LT**	Double Vision
RT	**LT**	Eye Injury: _______________	**RT**	**LT**	Tearing Eye
RT	**LT**	Blind Spot in Vision	**RT**	**LT**	Eye Redness
RT	**LT**	Crooked/Wavy lines	**RT**	**LT**	Eye Pain
RT	**LT**	Floating Spots/Cobwebs	**RT**	**LT**	Itchy
RT	**LT**	Droopy Lid	**RT**	**LT**	Foggy/Cloudy Vision
RT	**LT**	Glare or Halos	**RT**	**LT**	Matted eye in morning
RT	**LT**	Loss of side vision	**RT**	**LT**	Excessive Light Sensitivity
RT	**LT**	Eye Discharge	**RT**	**LT**	Feels like sand/lash in eye
RT	**LT**	Blurring of Vision	**RT**	**LT**	Rapid flashing lights (strobe effect)
RT	**LT**	Yellow tinted vision			

MEDICAL HISTORY

Do you take aspirin, Advil or any other over the counter pain medicines? **YES** **NO**

If **YES,** please list**:** ____

Do you take dietary supplements or herbal supplements? **YES** **NO**

If **YES,** please list**:** ____

Current Medical Problems:	**Current Medications & Dosages:**
Cancer ☐ None ☐ Yes (please list)	
Past Surgeries:	

ALLERGIES: None Yes (Please list): ____

CHECK ANY MAJOR OR RECENT SYMPTOMS

Constitutional:	Cardiovascular:	Metabolic/Endocrine:	Integumentary:
__ Fatigue __ Fever __ Night Sweats __Weakness __ Weight Gain __ Weight Loss	__ Arrhythmia __ Calf Pain __ Chest pressure or discomfort __ Irregular Heartbeat/palpitations __Leg Swelling __ Tachycardia	__ Cold Intolerance __ Heat Intolerance __ Excessive Thirst __ Excessive Hunger __ Excessive Urination	__ Abnormal hair distribution __ Dry Skin __ Hives __ Itching skin __ Nail Changes __ Rash __ Skin Changes __ Skin Lesions __ Skin nodules __ Skin sores __ Ulcer
HEENT:	**Gastrointestinal:**	**Neurological:**	**Musculoskeletal:**
__ Exophthalmos __ Hearing Loss __ Hoarseness __ Lump in Neck __ Nasal congestion __ Sinus Problems __ Sore Throat __ Tinnitus __ Vertigo	__ Abdominal Pain __ Black Tarry Stools __ Constipation __ Decreased Appetite __ Diarrhea __ Difficulty Swallowing __ Food Intolerance __ Heartburn __ Increased Appetite __ Jaundice __ Nausea __ Vomiting	__ Balance Disturbances __ Dizziness __ Focal Weakness __ Gait Disturbance __ Headache __ Memory Difficulty __ Numbness of Extremities	__ Arthralgia __ Back Pain __ Fracture __ Joint Stiffness __ Muscle Cramping __ Muscle Weakness **Hematologic/Lymphatic** __Bleeding __Bruising __Lymphadenopathy __ Tender Lymph Nodes
Respiratory:	**Genitourinary:**	**Psychiatric:**	**Immunologic:**
__ Asthma __ Cough __ Difficulty Breathing __ Difficulty Breathing on Exertion __ Coughing up of Blood __ Wheezing	__ Painful/Difficult Urination __ Genital Lesions __ Blood in Urine __ Irregular Menses __ Urethral Discharge __ Urgency	__ Depressed Mood __ Emotional Changes __ Euphoria __ Frequent Nightmares __ Hallucinations __ Insomnia __ Irritability __ Nervousness __ Stress	__ Environmental Allergies __ Food Allergies __ Seasonal Allergies Other: ________________________ ________________________ ________________________ ________________________ _____________________

FAMILY HISTORY

Any eye disease or blindness in relatives? YES NO If yes, who? ____________________________________

What kind of problem(s)? ____

Father: Still living? YES NO Age: ______

List medical problems: ____

Mother: Still living? YES NO Age: ______**List medical problems:**

____

SOCIAL HISTORY

Do you drive? YES or NO

Do you drive at night? YES or NO

Do you live with anyone? YES or NO If yes, Whom: ___________________________________

Do you have pets or animal exposure? YES or NO

If YES, what type of animals? ____

Do you use tobacco products? YES or NO

If YES, what type of tobacco? ____

How frequently? # packs per day or week? ____

Do you drink alcoholic beverages? YES or NO

If YES, how frequently? Drinks/day? ____

Do you use any recreational drugs? YES or NO

If YES, type of drugs and frequency: ____

Do you eat undercooked meat or fish products? YES or NO

Are you currently employed? YES or NO

Are you retired? YES or NO

What is or was your occupation? ____

I have completed this medical history to the best of my ability:

Signature: ____

Date: _____________________________________

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

FINANCIAL POLICY

- **The Patient is responsible for all fees. Full payment is due at time of service unless other arrangements have been made in advance.**
- **We will accept assignment on your insurance benefits and will expedite insurance claim processing to insure prompt payment and accurate reimbursement.**
- **Deductibles and copayments are due at time of service on all insurance plans.**
- **Patients covered under non-participating insurances must pay 100% of any unpaid deductible or out of pocket expenses under the terms of their contract.**
- **If insurance payment is not received within 60 days of your date of service, the Patient becomes responsible for the outstanding balance.**
- **Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. This charge will be assessed monthly until the account is paid in full.**
- **Delinquent unpaid balances including previous adjustments may be forwarded to a collection agency or attorney.**

I have read and understand this financial policy and agree to its terms. I agree to pay for services rendered. I agree to pay attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements:

Patient Signature ______________________ Date ______________________

Responsible Party ____________________________________ Date ______________________

I authorize the physicians and staff of Athens Retina Center to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

Patient Signature ___________________________ Date ____________

Guardian ____ Date______________________

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
ATHENS RETINA CENTER

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. (04/27/2016)

Patient Name (Print): ___________________________ Date of Birth: ______________

I authorize My Primary Care Doctor ____________________to be sent my records from Athens Retina Center: Yes No

I authorize the following person(s) to access my records from Athens Retina Center:

Name: ________________________________ Relationship: _________________________

Name: _______________________________ Relationship: ____________________

Name: ________________________________Relationship: ____________________

I, ____, hereby acknowledge receipt of the Notice of Privacy Practices Policy of Athens Retina Center and its physicians Mohan N. Iyer, M.D. , Victor T. Copeland, M.D. and William J. Carroll M.D

Patient Signature:_____________________ Date:_________________

This acknowledgement page should be retained in the patient's record.
If an acknowledgement could not be obtained from the patient, note the reasons below.

IF YOU WOULD LIKE A COPY OF OUR PRIVACY POLICIES PLEASE ASK THE FRONT DESK