Hart Eye Care
135 Ga. Hwy. 27 East
Americus, Ga. 31709
229-928-2024

Patient________________ ___ ________________ ___________
FIRST NAME MI LAST NAME PREFERRED NAME

Street Address______________________________ City__________ Zip__________
PHYSICAL ADDRESS

______________________________ City__________ Zip__________
P O BOX

Please Note: To file any insurance claims we must have a PHYSICAL ADDRESS

SSN__________ Date of Birth__________ Male___ Female___

Single/Married/Divorced/Widowed Spouse's (or Parent's)Name______________

Employer (or School)__________ Occupation (or Grade) ______________

Phone # Home____________ Cell______________okay to text: yes or no

Work____________ Email____________

Please circle preferred form of communication- Home, Work, Cell or Email

Medical Information

What is your general health? ______________________________

Do you wear? (circle) contacts glasses both

Weight__________***Height***______________***Pharmacy***______________

Do you have problems with any of these systems? (please circle all that apply) Eye **Y/N**

Gastrointestinal **Y/N** Nervous **Y/N** Mental **Y/N**

Ears/Nose/Throat **Y/N** Genitourinary **Y/N** Endocrine **Y/N**

Cardiovascular **Y/N** Musculoskeletal **Y/N** Blood/lymph **Y/N**

Respiratory **Y/N** Integumentary **Y/N** Allergic/immunologic **Y/N**

Please explain ______________________________

Please answer all that apply:

Diabetes **Y/N** Type ____________ Date of Diagnosis __________

Allergies **Y/N** Allergic to what? ________ What happens? __________

Medication allergy **Y/N** What Happens? ____________Headaches **Y/N**

Other health problems ______________________________

Current medication(s) ______________________________

Have you had any operations? **Y/N** Kind? __________ When? ______

Do you use cigarettes/tobacco? _____Alcohol? _____ Other substance(s)_____

Name of family doctor____________ ***Date of last visit***__________

Last Eye Exam______________ ***Doctor***__________

Family History

High blood pressure **Y/N** Relation _____ Macular degeneration **Y/N** Relation_____

Diabetes **Y/N** Relation __________ Retinal detachment **Y/N** Relation______

Glaucoma **Y/N** Relation __________ Cataracts **Y/N** Relation______

Other eye condition (s) **Y/N** What kind? __________Relation________

Personal Eye Information

Have you had any eye operations? **Y/N** Type __________Date______

Have you had an eye injury? **Y/N** Kind ____________Date______

Do you have glaucoma? **Y/N** Cataracts? **Y/N** Dry eyes? **Y/N** Blurred vision? **Y/N**

Other eye problems? **Y/N** What kind?______________________

Doctor's initials____________

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Authorization is herby granted to Hart Eye Care P.C. to release patients insurance company or other companies, their agents or third party payers, confidential or other information concerning the diagnoses, treatment or prognosis with the respect to any physical or mental conditions and/or treatment of the patient or any minor children (including copies of records) as may be requested or necessary for the completion of completion of claim possessing relating to patients office bills.

This authorization shall include information about drug/alcohol/chemical addition or treatment, psychiatric conditions, AIDS, HIV and other privileged information.

ASSIGNMENT OF MEDICARE BENEFITS
Patients certify that the following information given in Appling of payment under TITLE XVI I I of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Health Care Financing Administration or its intermediaries or carries any and all information needed for processing claims. Patient request that the payment of authorized benefits be made on patient behalf. Patients assigns the benefits payable for services render by Hart Eye Care P.C. And treating fractional and authorizes Hart Eye care P.C. and said practitioner to submit claims to Medicare for payment.

ASSIGNMENT OF MEDICAID BENEFITS
Patient authorizes any holder of medical or other information to release the Social Security Administrations or its intermediaries or carries any information needed of this or related Medicaid form. Patient herby assigns the benefits payable for the services rendered by Hart Eye Care and treating practitioner and authorizes Hart Eye Care, P.C. and said practitioner to submit claims to Medicare for payment.

AUTHORIZATION FOR RECOVERY OF INSURANCE BENEFITS
For the care and treatment received, Patient herby authorizes Hart Eye Care to receive all insurance benefits and settlements, whether hospital, medical, or liability insurance, but not limited to the proceeds and any settlement or judgment of any third party claim. To the extent of any and all services renders and grants Hart Eye care lien upon all such benefits or third party claims or recoveries. Patient herby authorizes direct payment to Hart Eye Care of such benefits or third party claims r recoveries.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 118Bof the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information

FILING OF THIRD PARTY CLAIMS
Patient acknowledges that, upon proof of coverage, Hart Eye Care will submit a claim for payment insurance benefits and accept payment form third party payers to be credited to this account as they are received. Patient agrees that the filing of insurance claims is performed as a service and in no way relives patient of the obligation to pay in full. Patient understands that it is their responsibility to follow up with any insurance company or employer within 30 days to see that patient's bill is paid promptly.

For SGHA covered; Patient agrees to fulfill health plan requirements of deductibles and co-payments. Provider will file insurance claim per the SGHA contract. Patient acknowledges responsibility for payment in full for deductible \, denial by the insurance company as not covered. And not medically necessary as per the terms of the SGHA contract.

If patient overpayment occurs, patients assigns credit to be applied to be to existing unpaid account for which the patient of the account for which the insured guarantor also responsible, and that all over payments not so assigned will be refunded to the patient or guarantor. The patient or guarantor also acknowledged that there would be responsible for payment full payment of the account if denied by the insurance company as not covered or not medically necessary.

PATIENT CERTIFICATION
Patient, or the undersigned representative authorized to act on patients behalf, herby certifies that this form has been read and understood and that satif\sfactory explanations have been given for any questions asked. If this form is signed by Patient's representative, then such representative herby certifies that he/she has the legal rights to consent to the patient and agrees to indemnify Hart Eye Care from any liability to patient arising from such representative's actions in signing this form on patients behalf.

VALIDITY OF FORM
Patient herby authorizes that a copy of this document may be used in place of and is a valid as the original.

Date ______________ **Patient** ______________________

Patient Agent or Representative ______________________

Guarantor/Relationship to patient ____________________