WALTON EYE CARE
& LASER CENTER

Come See With Us!

Stephen A. Baynham, M.D.

517 GREAT OAKS DRIVE • SUITE 101 • MONROE, GA 30655 • 770-267-4561

Please Print

Name: _____

Street: _____

PO Box: _____

City: _____ State _____ Zip _____

Give us your telephone numbers please:

Home # _____ Work # _____

Cell# _____

Employer (or School): _____

Occupation (or Grade): _____

Email: _____

Who is the subscriber for your insurance? _____

Subscribers Social Security _____

Subscribers Date of Birth _____

Emergency Contact: _____

Today's Date: _____

Date of Birth: _____ Age: _____

Sex: M ☐ F ☐ Social Security #: _____

Ethnic Origin: Asian Black Caucasian Hispanic
(Circle Choice)

Marital Status: Single Married Separated
Divorced Widowed
(Circle Choice)

Spouse or Parent Name: _____

Spouse or Parent Work Phone: _____

Your regular physician: _____

Referring Dr. : _____

Nearest Relative Not Living With You: Relationship: Phone:

The following information is very important to your health. Please take the time to fully and accurately complete this form!

Eye History

Check this box if you have NO eye problems or symptoms: ☐ I have no eye problems

Do you have a history of eye problems other than glasses? ☐ Glaucoma ☐ Retinal Disease ☐ Cataract
☐ Other _____ ☐ Eye Surgery _____

Do you wear contact lenses? ☐Yes ☐No ***If yes, what type and power are your lenses?*** _____

Do Your Eyes Experience Any of the Following?

☐ Burning	☐ Flashes of Light	☐ Strain/Headache
☐ Sensitivity to Light	☐ Floating Objects	☐ Gritty Feeling
☐ Excessive Tearing	☐ Blurry Distance Vision	☐ Itchiness
☐ Difficulty Seeing at Night	☐ Blurry Near Vision	☐ Soreness
☐ Uncomfortable Glasses	☐ Sudden Loss of Vision	☐ Redness
☐ Uncomfortable Contact Lenses	☐ Glare or Reflection	☐ Dryness
☐ Double Vision	☐ Difficult Night Driving	☐ Difficult Day Driving
☐ Difficult Reading Small Print	☐ Difficult Seeing Steps/Curbs	☐ Problems Seeing Faces
☐ Difficult Reading Medium Print	☐ Difficult Reading Signs	☐ Problems with Fine Handiwork
☐ Difficult Reading Large Print	☐ Problems Seeing to Play Sports	☐ Problems Seeing to Play games
☐ Problems Seeing to Cook	☐ Problems Seeing to Watch TV	☐ Problems filling out forms

What is the MAIN purpose of this visit? What do you want to accomplish by seeing the doctor today?

PAYMENT IN FULL IS REQUIRED WHEN SERVICES ARE RENDERED IF THERE IS NO INSURANCE COVERAGE

You will be responsible for any portion of your bill which is not paid for by your insurance company.

(Please continue on back)

Family Medical History

			Relationship
Blindness	☐ Yes	☐ No	_____
Cataracts	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Hypertension	☐ Yes	☐ No	_____
Retinal Disease	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____
Heart Attack	☐ Yes	☐ No	_____

Social History

Do you smoke? ☐ Yes ☐ No
If yes, how much per day? _____
Smoking Cessation Counseling Done: Yes

Drink alcohol? ☐ Yes ☐ No
Have you ever had a problem with drug abuse?
☐ Yes (see below) ☐ No
How much? _____
If so, what drug? _____ When? _____

YOUR MEDICAL HISTORY

Medication Allergies: _____

_____

Major Surgeries: _____

_____

Review of Systems: If "YES" List Date of Problem

Cardiovascular (Heart)	☐ Yes	☐ No	_____
Heart Attack?	☐ Yes	☐ No	_____
High Blood Pressure?	☐ Yes	☐ No	_____
Vascular Disease?	☐ Yes	☐ No	_____
Ear,Nose,Throat,Mouth	☐ Yes	☐ No	_____
Endocrine: **Diabetes**	☐ Yes	☐ No	_____
Insulin Use	☐ Yes	☐ No	_____
Thyroid	☐ Yes	☐ No	_____
Hormone	☐ Yes	☐ No	_____
Gastrointestinal	☐ Yes	☐ No	_____
Ulcer?	☐ Yes	☐ No	_____
Reflux?	☐ Yes	☐ No	_____
Bleeding?	☐ Yes	☐ No	_____
Genitourinary	☐ Yes	☐ No	_____
Kidney Stones?	☐ Yes	☐ No	_____
Bladder Infections?	☐ Yes	☐ No	_____
Immune System	☐ Yes	☐ No	_____
Problems with Your Immune System?	☐ Yes	☐ No	_____
Hematologic/Lymph	☐ Yes	☐ No	_____
Integumentary (Skin)	☐ Yes	☐ No	_____
Musculoskeletal	☐ Yes	☐ No	_____
Neurological	☐ Yes	☐ No	_____
Stroke?	☐ Yes	☐ No	_____
Psychiatric	☐ Yes	☐ No	_____
Reproductive	☐ Yes	☐ No	_____
Are You Pregnant?	☐ Yes	☐ No	_____
Are You Breast feeding?	☐ Yes	☐ No	_____
Menopause?	☐ Yes	☐ No	_____
Prostate Disease?	☐ Yes	☐ No	_____
Herpes?	☐ Yes	☐ No	_____
Other STD?	☐ Yes	☐ No	_____
Respiratory	☐ Yes	☐ No	_____
Asthma?	☐ Yes	☐ No	_____
COPD?	☐ Yes	☐ No	_____
Cancer History?	☐ Yes	☐ No	_____
Chemotherapy?	☐ Yes	☐ No	_____
Radiation?	☐ Yes	☐ No	_____

Type of Cancer? _____

Medications (including Non-Prescription such as Aspirin, etc.)

Medicine Dosage How Often?

_____

_____

_____

_____

_____

_____

_____

_____

Eye Drops

_____

_____

_____

_____

Drug Store: ***Drug Store Phone:***

_____

Other Important Health History Please Describe Here:

_____

_____

_____

_____

_____

Patient Name:

Medical Exam Vs. Routine Exam

(Please read carefully and sign below)

MEDICAL EYE EXAM:

Dr. Baynham is a medical doctor (M.D.) who specializes in the eye. He is an ophthalmologist, not an optometrist. Although Dr. Baynham does check your vision for glasses and/or contacts, he does much more than that. Dr. Baynham is trained to diagnose and treat diseases of the eye as well as prescribe medications and perform surgery. A medical exam takes place when you are being evaluated or treated for a medical condition or symptom that you bring up, eye problems you tell our staff about, or conditions that the doctor finds during the exam. Some examples that necessitate your visit being submitted to your medical insurance include eye irritation, dry eyes, allergies, watery eyes, diabetes, floaters, double vision, glaucoma, cataract, and macular degeneration. For this reason, we file claims to MEDICAL INSURANCE with a medical diagnosis and medical codes.

Routine Eye Exam:

A routine eye exam takes place when you come for an eye exam without any medical problems, and there are no symptoms except for visual changes that can be corrected by eyeglasses or contact lenses. The doctor finds no evidence of disease or medical problems during the course of the exam. Routine eye exams are billed to your vision care plan (VSP, Eyemed, Spectera, etc) or to your medical provider only if you have routine vision coverage as part of your insurance plan. If you have a "routine" or "free one time a year" vision benefit, *it is your responsibility to know and inform us at the time of check in.*

Due to the many insurance companies and variable policies, we cannot possibly know if you have that benefit included in your medical insurance. There are simply too many different insurance companies, plans, carriers and constant changes for us to be able to answer questions regarding your individual coverage.

_____

Initial I have read

We always encourage you to get a medical exam to check the health of your eye, however, if you have no medical problems and have a "routine" benefit you want to use or just check your eyes for glasses or contacts, *you must notify the receptionist at the time of check in. Once you have seen Dr. Baynham, this cannot be changed.* Please be aware that if your insurance company denies the claim, and/or applies the amount to your deductible, then you are responsible for paying that amount to our office.
Please be sure you have verified the benefit with your insurance, as we will not be able to re-file the claim to your insurance.

I have read this policy & agree to have a *MEDICAL EXAM* & have my Medical insurance filed for my exam today. (Please provide your insurance card at check in.) If you have *NO INSURANCE AND WILL BE SELF PAY TODAY, SIGN HERE* (*you will be receiving a medical exam)*

Signed_____ Date_____

I have read this policy and agree to have a *VISION EXAM* only & have my vision insurance filed for my exam today. OR, I have a routine exam benefit included in my medical insurance. I understand that if Dr. Baynham should find a medical condition once I am examined, then my visit today will be filed to my medical insurance and I will be informed of this. (*Do NOT sign here if you signed above that you want a medical exam) HOWEVER, if we are only using your vision insurance to file for glasses or contact lenses then put a check mark by your vision coverage as well as the policy holder info below.*

Signed_____ Date_____

I have the following Vision Only Coverage: *(these are the ones we accept)*

____VSP____EYEMED____VCP ____SPECTERA _____Benefit included in my Medical insurance

Policy Holder Name _____

Date of Birth of Policy Holder_____

Vision Insurance ID# and/Or Social Security Number_____
(if you do not have a vision id card with an ID# on it, we will need your SSN to verify benefits.)

To Our Patients With Insurance Coverage: (PLEASE SKIP TO BOTTOM IF YOU HAVE NO INSURANCE)

As a courtesy to our patients, we will gladly enter your insurance information into our computer and automatically file your insurance for you each time you come in. We request that you allow us to make a copy of your insurance card so that we enter all of the information correctly and to insure that it is sent to the correct address. We ask that you keep us informed of any and all changes in your insurance coverage as soon possible.

To keep your account current and your credit in good standing, you will be asked to pay for all medical services in full while your deductible is being met. We also ask that you pay your patient responsibility amount when services are received. This amount varies from company to company. Example: some patients are responsible for 20% & the insurance company pays the remaining 80%. If your insurance company has not paid within 30 days, in fairness to us we ask you to please pay your balance in full. Also, if we are not participants with your plan, your insurance may deny payment, reduce payment, or increase your deductible amount. *Due to the constant changes in insurance policies and procedures, we regret that the burden of determining if our services will be covered by your insurance company must rest with you. There are simply too many different insurance companies, plans, carriers, and constant changes for us to be able to answer your questions regarding your individual coverage. We have a telephone available to you so that you can call your insurance with any questions.*

Monthly you will receive a statement from our office showing any payments made by your insurance and the amount they say you are responsible for.

We appreciate your allowing us to be your health care providers and we are glad we are able to offer you the service of filing your insurance. However, your medical care costs are ultimately your responsibility, regardless of insurance coverage. If you have any confusion or questions regarding your medical treatment or charges, please ask for clarification before leaving the office, we are here to help.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Dr. Baynham/Walton Eye Care, Inc. and I authorize the release of any medical information necessary to process my medical claims. I also understand that I am financially responsible for all service rendered and any fee and/or interest imposed by outside agencies in effort to collect delinquent account balances.

To Our Patients without Insurance: We do require payment of $100.00 to be made on arrival. If further testing or procedures are needed, the balance will be due when you check out.

To All New and Established Patients: There will be a $25.00 fee assessed to your account for all missed appointments OR appointments not cancelled at least 24 hours prior to appointment. We kindly ask that you give our office 24 hrs. notice if you are unable to keep your appt.

Patient/Guarantor Signature Date

_____ _____

[WALTON EYE CARE, INC.]

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for WALTON EYE CARE (PRACTICE) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by PRACTICE describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at PRACTICE.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Suanne Smith at PRACTICE

With this consent, PRACTICE may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PRACTICE may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, PRACTICE may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, [insert name of practice] may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

PRINTED NAME _____ DOB: _____

REGARDLESS OF WHETHER YOU WEAR GLASSES, OR THINK YOU DON'T NEED THEM, <u>EVERYONE</u> PLEASE READ AND SIGN BELOW

<u>Glasses Financial & Remake Policy</u>

We appreciate your allowing us to meet your eye care needs, and Want you to be happy with your choices. However, due to lab costs In making each pair of glasses, there must be financial policies in place. *The optical shop has a ***30 day*** remake policy. If you should have A problem with your eyeglasses, ***you must notify us within 30 days*** from the date of purchase. The lab will remake the lenses at no charge one time only. If you decide to return the glasses within 30 days, there will be a 40% Restocking fee. ***A full refund will not be issued***. The lab charges us, and the frame can no longer be sold. Regardless of the reason, once the 30 days has passed there will be NO Refund issued and glasses will not be re-made after the expiration of the warranty period. After the 30 day period, All Sales are Final. *Thank you!*

By signing below, I indicate that I have read and understood the glasses remake and financial policy:

_____ _____

PATIENT SIGNATURE **DATE**