WALTON EYE CARE

517 GREAT OAKS DRIVE, SUITE 100
MONROE, GEORGIA 30655

PATIENT INFORMATION

LAST NAME: _____ SUFFIX: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)

_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: _____ FEMALE _____ MALE

RACE: _____ ETHNICITY: _____

LANGUAGE: _____ TRANSLATOR NEEDED: ____ YES ____ NO

EMERGENCY CONTACT: _____ PHONE #: _____

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: _____

PARENT NAME (IF MINOR): _____ PHONE #: _____

PRIMARY CARE PHYSICIAN FIRST & LAST NAME: _____

REFERRING PHYSICIAN FIRST & LAST NAME: _____

IF A PROVIDER DID NOT REFER YOU, HOW DID YOU HEAR ABOUT US?

FRIEND OR FAMILY MEMBER GOOGLE OR WEB SEARCH SOCIAL MEDIA

OTHER: _____

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 BY YOUR INSURANCE COMPANY.

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*INSURANCE INFORMATION

VISION INSURANCE

NAME OF INSURANCE: _____

MEMBER ID: _____

INSURED'S NAME: _____

INSURED'S DATE OF BIRTH: _____

SSN OF INSURED: _____

MEDICAL INSURANCE

NAME OF INSURANCE: _____

MEMBER ID: _____

INSURED'S NAME: _____

INSURED'S DATE OF BIRTH: _____

SSN OF INSURED: _____

* Please understand that the financial responsibility for your account is yours, not the responsibility of your insurance company. We do not guarantee the accuracy of benefits information given to us by insurance companies. Most insurance policies only pay a portion of your total charges. If you have any questions about your coverage, please contact your insurance representative. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept the assignment. I understand that I am responsible for any balance my insurance does not pay.

PATIENT NAME (PRINT FIRST & LAST NAME):

_____

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MEDICAL INFORMATION

VISION INFORAMTION:

DO YOU WEAR: _____ GLASSES _____ CONTACTS

IF "YES" TO CONTACTS, ADDITIONAL FEE APPLIES FOR CONTACT LENS EVALUATION. FIRST TIME CONTACT LENS WEARERS MUST HAVE INSERTION AND REMOVAL TRAINING.

IF YES TO CONTACT LENSES: _____ SOFT _____ HARD

WHAT TYPE & POWER ARE LENSES: _____

ARE YOU HAVING ANY VISION PROBLEMS TODAY?

_____ YES _____ NO (IF YES, PLEASE CHECK ALL THAT APPLY)

- ☐ BURNING
- ☐ SENSITIVITY TO LIGHT
- ☐ EXCESSIVE TEARING
- ☐ DIFFICULTY SEEING AT NIGHT
- ☐ UNCOMFORTABLE GLASSES
- ☐ UNCOMFORTABLE CONTACTS
- ☐ DOUBLE VISION
- ☐ DIFFICULTY READING SMALL PRINT
- ☐ DIFFICULTY READING MEDIUM PRINT
- ☐ DIFFICULTY READING LARGE PRINT
- ☐ PROBLEMS SEEING TO COOK
- ☐ FLASHES OF LIGHT
- ☐ FLOATING OBJECTS
- ☐ BLURRY DISTANCE VISION
- ☐ BLURRY NEAR VISION
- ☐ SUDDEN LOSS OF VISION
- ☐ GLARE OR REFLECTION
- ☐ DIFFICULT TO DRIVE AT NIGHT
- ☐ DIFFICULTY SEEING STEPS/CURBS
- ☐ DIFFICULTY READING SIGNS
- ☐ PROBLEMS SEEING TO PLAY SPORTS
- ☐ PROBLEMS SEEING TO WATCH TV
- ☐ STRAIN/HEADACHE
- ☐ GRITTY FEELING
- ☐ ITCHINESS
- ☐ SORENESS
- ☐ REDNESS
- ☐ DRYNESS
- ☐ DIFFICULT DAY DRIVING
- ☐ DIFFICULTY SEEING FACES
- ☐ PROBLEMS WITH FINE HANDWORK
- ☐ PROBLEMS SEEING TO PLAY GAMES
- ☐ PROBLEMS FILLING OUT FORMS

SOCIAL HISTORY

ARE YOU CURRENTLY A SMOKER? ___ YES ___ NO; IF YES, HOW MUCH PER DAY? _____

SMOKING CESSATION COUNSELING DONE: ___ YES

DO YOU REGULARLY DRINK ALCOHOL? ___ YES ___ NO

HAVE YOU EVER HAD A PROBLEM WITH DRUG ABUSE? ___ YES ___ NO

IF YES, WHAT DRUG? _____ HOW OFTEN? _____ WHEN? _____

FAMILY OCULAR HISTORY: (IF YES, PLEASE PUT WHO IN YOUR FAMILY HAD THIS DISEASE)

BLINDNESS	YES	NO	RELATIONSHIP: _____
CATARACTS	YES	NO	RELATIONSHIP: _____
EYE SURGERY	YES	NO	RELATIONSHIP: _____
GLAUCOMA	YES	NO	RELATIONSHIP: _____
MACULAR DEGENERATION	YES	NO	RELATIONSHIP: _____
RETINAL DISEASE	YES	NO	RELATIONSHIP: _____

OTHER _____

PATIENT NAME (PRINT FIRST & LAST NAME):

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PERSONAL MEDICAL INFORMATION

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

ALLERGIES: _____

MAJOR SURGERIES: _____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING AREAS? **IF YES, PLEASE 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 DISEASE	YES	NO	
HORMONE PROBLEM	YES	NO	
GASTROINTESTINAL	YES	NO	
ULCERS	YES	NO	
RELFUX	YES	NO	
BLEEDING	YES	NO	
GENITOURINARY	YES	NO	
KIDNEY STONES	YES	NO	
BLADDER INFECTIONS	YES	NO	
IMMUNE SYSTEM PROBLEMS	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 BREASTFEEDING?	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	IF YES, TYPE OF CANCER: _____
CHEMOTHERAPY	YES	NO	
RADIATION	YES	NO	

PATIENT NAME (PRINT FIRST & LAST NAME):

_____

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CURRENT MEDICATIONS

CURRENT MEDICATIONS, INCLUDING NON-PRESCRIPTION SUCH AS ASPIRIN, SUPPLEMENTS, ETC:

NAME OF MEDICATION	DOASGE	HOW OFTEN?

PHARMACY NAME: _____ PHONE: _____

PLEASE DESCRIBE ANY ADDITIONAL IMPORTANT HEALTH HISTORY HERE:

_____

_____

_____

_____

_____

_____

PATIENT NAME (PRINT FIRST & LAST NAME):

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MEDICAL EXAM VERSUS ROUTINE EXAM

(PLEASE READ CAREFULLY AND SIGN BELOW)

MEDICAL EYE EXAM:
The providers at Walton Eye Care are medical doctors (MD's) who specialize in the eye. They are ophthalmologists, not optometrists. Although the providers do check your vision for glasses and/or contacts, they do a much more thorough exam. Walton Eye Care providers are 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 provider 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, bloaters, double vision, glaucoma, cataracts, 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 provider 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.

PATIENT OR GUARDIAN NAME (PRINT FIRST & LAST NAME):

_____

DATE OF BIRTH: _____ /_____ /_____

PATIENT OR GUARDIAN SIGNATURE:

_____

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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 front desk staff at the time of check-in. Once you have seen the provider, 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 the amount to our office. Please be sure you have verified the benefit with your insurance, as we will not be able to refile 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, SIGN BELOW (you will be receiving a medical exam.)

PATIENT OR GUARDIAN NAME (PRINT FIRST & LAST NAME):

_____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE:

_____

I have read this policy and agree to have a VISION EXAM & have my Medical insurance filed fir my exam today. OR, I have a routine exam benefit included in my medical insurance. I understand that if Dr. Baynham OR Dr. Tammaro 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 checkmark by your vision coverage as well as the policy holder information below.

PATIENT OR GUARDIAN NAME (PRINT FIRST & LAST NAME):

_____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE:

_____

☐ VSP ☐ EYEMED ☐ VCP ☐ SPECTERA ☐ BENEFIT INCLUDED IN MY MEDICAL INSURANCE

POLICY HOLDER NAME (PRINT): _____

POLICY HOLDER'S DATE OF BIRTH: _____/_____/_____

VISION INSURANCE ID# AND/OR SOCIAL SECURITY NUMBER: _____

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PATIENTS WITH 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 ensure 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 as 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. For example, some patients are responsible for 20% and 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 in 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 healthcare provider 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 changes, 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 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 services rendered and any fee and/or interest imposed by outside agencies in an effort to collect delinquent account balances.

PATIENTS WITHOUT INSURANCE:
We do require a self-pay rate payment to be made on arrival. If further testing or procedures are needed, the balance will be due when you check out.

FOR ALL PATIENTS (New and/or Established Patients):
There will be a $25.00 fee assessed to your account for all missed appointments or appointments not canceled at least 24 hours prior to the appointment. We kindly ask that you give our office 24 hours' notice if you are unable to keep your appointment.

PATIENT OR GUARDIAN NAME (PRINT FIRST & LAST NAME):

_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION NOTICE OF PRIVACY PRACTICES

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

I have the right to review the Notice of Privacy Practices prior to signing this consent. Walton Eye Care, Inc. 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 Walton Eye Care, Inc.

With this consent, Walton Eye Care, Inc. may call my home or another alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in caring for our Treatment, Payment, and Healthcare Operations such as appointment reminders, insurance items, and any calls pertaining to my clinical care including laboratory test results, among others.

With this consent, Walton Eye Care, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment, and Healthcare Operations such as appointment reminder cards and patient statements.

With this consent, Walton Eye Care, Inc. may e-mail any items that assist the practice in carrying out Treatment, Payment, and Healthcare Operations such as appointment reminder cards, patient statements, patient receipts, glasses, and/or contact lens prescriptions. I have the right to request that Walton Eye Care, Inc. restrict how it uses or discloses my PHI to carry out Treatment, Payment, and Healthcare Operations. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Walton Eye Care, Inc. to use and disclose my PHI to carry out treatment, payment, and healthcare operations. Walton Eye Care, Inc. may also disclose my PHI to the following family members and/or individuals (please list first and last names along with relationship):

_____

_____

_____

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, Walton Eye Care, Inc. may decline to provide treatment to me.

TODAY'S DATE: _____ PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE: _____

IF APPLICABLE, GUARDIAN NAME (PRINT): _____

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AUTHORIZATIONS

This authorization is used to obtain authorization to release information regarding yourself, covered under the Privacy Act, to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself (or my child if a minor):

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

TODAY'S DATE: _____ PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE: _____

IF APPLICABLE, GUARDIAN NAME (PRINT): _____

ELECTRONIC COMMUNICATIONS

By submitting your email address to our practice you have granted us permission to communicate with you electronically. By utilizing our practice's electronic services, you agree that Walton Eye Care, Inc. may send to you any of the following that can be sent through the internet to an email address you designate.

I, _____, agree that Walton Eye Care, Inc. may electronically communicate with me at the following email address.

EMAIL ADDRESS: _____

Acknowledgment and Consent that Walton Eye Care, Inc. may send the following by email: Information about my invoice or accounts payable, any eye care visits (including appointment reminders), photos and prescriptions, or any information that I request be sent by email. Communication from Walton Eye Care, Inc. will be encrypted, the patient is responsible for providing an updated email address, the patient is able to receive information electronically and store it securely away from any public computer and I can withdraw my consent to electronic communication by calling the office at 770-267-4561.

TODAY'S DATE: _____ PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE: _____

IF APPLICABLE, GUARDIAN NAME (PRINT): _____

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REGARDLESS OF WHETHER YOU WEAR GLASSES, OR THINK YOU DON'T NEED THEM,
EVERYONE MUST READ AND SIGN BELOW:

FINANCIAL & REMAKE POLICY

We appreciate your allowing us to meet your eye care needs, and we 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 Walton Eye Care 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 have 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!

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

TODAY'S DATE: _____ PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE: _____

IF APPLICABLE, GUARDIAN NAME (PRINT): _____