Advanced Eye Center
Medical History Questionnaire

____

Patient's Full Name   Date of Birth   Today's Date

____   ______________________________

Please list reason(s) for your exam today   Referring Doctor

Primary Care Medical Doctor ________________________________   Pharmacy______________________

Occupation: ______________________ Race: _____________ Language: _____________ Marital Status: ______________

ILLNESSES – Please circle if applicable

Diabetes - If yes Onset: __________   Type I / Type II   Last A1C: ________   Last Blood Sugar: _______

High Blood Pressure
Stroke
Heart Attack   Date: ____________
Heart Failure   Date: ____________
Heart Rhythm Problem
Arthritis
Asthma

Cancer
Hepatitis
Thyroid
Glaucoma
Please list any others:
____
____

Have you taken in the past, or, are currently taking the following:

Flomax (Tamsulosin)
Cardura (Doxazosin)
Hytrin (Terazosin)
Minipres (Prazosin)
Rapaflo (Silodososin)
Saw Palmetto

Oxytrol (Oxybutynin)
Ditropan (Oxybutynin)
Gelnique (Oxybutynin)
Uroxatral (Alfuzosin)
Jalyn (Dutasteride / Tamsulosin)
Finesteride

Allergies to Medications: Yes   No

If yes, please list:

____   Reaction: ____

Do you drink alcohol?   Yes   No   How many glasses / day?   _________________________

Do you smoke?   Yes   No   How many packs / day?   _________________________

Surgeries and/or Hospitalizations and the reason for them:

____
____
____

Eye Surgeries and/or Injuries (please list type and date)

____
____

Revised 09/22/20

TURN PAGE, COMPLETE BOTH SIDES

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Do you presently have any problems in the following areas?

			Explanation of Problem
Integument (Skin)	Yes	No	___
Head	Yes	No	___
Eyes	Yes	No	___
Ears, nose, mouth, throat	Yes	No	___
Neck	Yes	No	___
Respiratory (lungs/breathing)	Yes	No	___
Cardiovascular (heart/blood vessels)	Yes	No	___
Gastrointestinal (Stomach/intestines)	Yes	No	___
Genitourinary (genitals/kidney/bladder)	Yes	No	___
Bones, Joints, muscles	Yes	No	___
Neurological system	Yes	No	___
Lymphatic (lymph nodes/swelling)	Yes	No	___
Hematopoietic (blood)	Yes	No	___
Allergic, immunologic	Yes	No	___
Psychiatric	Yes	No	___

Would you be interested in more information in vision correction procedures? Yes No

Family History
Do any family members have any problems with the following?

			Relationship to Patient
Blindness	Yes	No	___
Cataract	Yes	No	___
Glaucoma	Yes	No	___
Macular Degeneration	Yes	No	___
Retinal Detachment	Yes	No	___
Arthritis	Yes	No	___
Cancer	Yes	No	___
Diabetes	Yes	No	___
High Blood Pressure	Yes	No	___
Kidney Disease	Yes	No	___
Stroke	Yes	No	___
Thyroid Disease	Yes	No	___
Other			___

ADVANCED EYE CENTER

William C. Ackerman, Jr., M.D. LeRoy W. Robinson, III O.D. Taylor E. Rossow, D.O.

Date: ___________________________

Patient's Full Name: ____ Maiden Name: __________________

Date of Birth: ___________________________ Age: _______ Male/Female Social Security #: ___________________

Address: ____ Apt. #: _______________

City, State, Zip: ______________________________ Race: ___________ Ethnicity: ___________ Language: ____________

Cell Phone: ________________________________ Home Phone: ________________________________

Email address: ________________________________ Preferred Contact method: Text message / Email / Phone

Medical Doctor: _______________________________ Referring Doctor: ____________________________

Pharmacy Name: ______________________________ Pharmacy Number: ___________________________

Person to contact in emergency

Name: __________________________________ Relationship: ________________ Phone: ___________________

Person(s) we may discuss your information with ______________________________________ Relationship: _____________

Home Phone: ___________________ Work Phone: _____________________

Spouse or Parent's Name: ________________________________ Phone: ________________________________

Employer: ____ Work Phone #: __________________________

Is this visit work related? ____ Date of Injury: ______________________

How did accident occur? ____

Will your services be filed to Workers Compensation: Yes / No

Insurance

I hereby authorize payment of my medical and surgical insurance benefits to Advanced Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Advanced Eye Center. I authorize Advanced Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

Signed: ____ Date: ____________________________

Acknowledgement of receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: ____ Date: ____________________________

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William C. Ackerman, Jr., M.D. LeRoy W. Robinson, III, O.D. Taylor E. Rossow, D.O.

Patient Financial & Office Policy
January 1, 2020

In order to give the best possible care to our patients, we have implemented this patient office policy. Please read and sign this form acknowledging that you understand the information in the policy. Please ask the office staff if you need clarification or have any questions.

- **MEDICAL INSURANCE PLANS:** In an effort to make our practice as accessible and affordable as possible we are contracted with numerous insurance plans. Each of the plans have specific rules that must be followed by the insured (you) and the healthcare provider (us) in order to be in compliance. Our primary goal is to provide optimal medical care for our patients. However, we are required to provide that care within the guidelines of your insurance plan. Please remember it is your responsibility to understand the requirements of your insurance plan. It is of utmost importance that you keep us up-to-date on any changes in your status: (eg., new insurance, new address, new phone number).

- **MEDICAL TESTING:** Additional testing may be deemed necessary by your provider to diagnose, monitor, and/or treat your medical eye condition (diabetes, cataract, glaucoma suspect, glaucoma, macular degeneration, etc.). Charges for these tests are separate from the exam charge and will be submitted to your insurance. Your responsibility for the testing will be based upon your individual insurance benefit plan and the processing of these charges by your insurance. You will be billed for any portion deemed your responsibility by your Insurance company.

- **VISION INSURANCE:** Vision Insurance provides a baseline wellness exam of the eye for patients with no eye disorders. If you have an eye disorder that requires more than a wellness exam those services will be filed to your medical insurance separately.

- **CO-PAYS, DEDUCTIBLES AND CO-INSURANCE:** All co-pays and outstanding balances are due at the time of service. Some insurance plans may apply your office visit to your deductible. **Self-pay patients must pay charges on the date of service**. Accepted payment methods are cash, check, credit or debit cards (MasterCard, Visa, Discover).

- **IDENTIFICATION:** We do ask that you provide us with a photo ID and your insurance cards. This helps us to identify you and make it possible to file your insurance. We may ask to see these cards at each visit.

- **APPOINTMENTS:** Our office requires you to have an appointment. If you are having an urgent issue please call our office and ask to be seen. A message will be taken and given to your physician and we will respond as quickly as possible with a work-in appointment time.

- **CHECK POLICY:** We will gladly accept your personal check, however, our returned check fee is $30.00

- **COLLECTION ACCOUNTS:** If your account is turned over to a collection agency, you will not be able to make any future appointments, or, have any prescriptions refilled until your account is paid in full.

- **DISABILITY FORMS:** There is a $15.00 charge for completion of disability forms.

- **MEDICAL RECORDS:** There is a $25.00 charge for reproduction of your medical records. If we refer you to another physician's office, there will not be a charge.

- **NO-SHOW APPOINTMENT POLICY:** We require a 24-hour notice for all appointment cancellations.

- **PHONE CALLS/VOICE MAILS:** We strive to return all patient calls on the same business day, however, if you are calling late in the afternoon, your call may not be returned until the next business day.

- **REFERRALS:** Many insurance plans require a REFERRAL. Specifically, a referral is a written document with a referral number which authorizes you to be seen by our physicians. Your primary care physician obtains the referral from your insurance company. If a referral is required, and you do not have a referral for your appointment, we will reschedule your appointment for a later date, or, you may pay for the appointment in full at the time of service.

- **REFILLS:** Please ask for refills at your appointment. If you need a refill in-between appointment please call our office. You may leave a message on the prescription refill option or request your pharmacy to send a refill request to us. Please allow 24 hours for your refill to be sent in.

- **CONTACT LENS AND CONTACT LENS EXAM:** Contact lenses are considered to be a medical device by the FDA (Food and Drug Administration) and are therefore regulated by prescription laws. Georgia Law requires an annual comprehensive eye exam with a contact lens assessment in order to receive a contact lens prescription, or, for us to dispense the contact lens. The contact lens assessment is a separate and additional component to the comprehensive eye exam and is subject to an annual fee in addition to the comprehensive eye exam. Most insurance plans do not provide coverage for contacts or contact lens related services. **You are responsible for your co-pay for the eye exam as well as, the fee for refraction and the fee for the contact lens assessment on the date of service.** We do participate with VSP (Vision Service Plan) and Blue View Vision. Related charges will be filed to VSP and Blue View Vision provided benefits are available with your particular plan.

- **REFRACTION FEE:** A refraction is the process of determining the eye's best corrected vision or need for corrective lenses. **Refractions are considered a vision care service and are NOT covered by Medicare and most medical insurances.** Payment for the refraction is due on the day of your exam and is in addition to any co-pay or deductible required by your insurance plan. The refraction charge will be submitted to your insurance and if payment is received from insurance you will be reimbursed accordingly. **Medicare statutorily excludes payment for determination of refractive state. An eye refraction is never covered by Medicare and will be due from patient's with Medicare upon check out from your visit on the date of service.**

  Vision Plans: We participate with VSP and Blue View Vision. These vision plans provide an allowance for the refraction and will be filed along with your exam for reimbursement as applicable.

Acknowledgement of receipt of Patient Office Policy

In order to provide the best possible care to our patients we have implemented a patient office policy. I understand that by signing I am acknowledging that I have received a copy of this office policy for my review.

Signature: ____________________________________ Date: _________________

Print Name: __________________________________

Updated July 1, 2020