



NORTH GEORGIA EYE CLINIC & LASER CENTER

an its affiliates in:

■ **Gainesville**
535 Jesse Jewell Pkwy. , Ste. C
Gainesville, GA 30501

■ **Gainesville**
1016 Thompson Bridge Road
Gainesville, GA 30501

■ **Ellijay**
296 Sailors Drive
Ellijay, Georgia 30540

■ **Clayton**
485 North Main Street
Clayton, Georgia 30525

Date: _____

*If your appointment was made by a referring physician, please list physician's name and telephone _____

Who is your primary care physician: _____

Patient Name Birthdate Home Phone Number Social Security Number

Mailing Address

Physical Address (If Different than Mailing Address)

Place of Employment Occupation Business Phone Number

Employer Street Address or P.O. Box City State Zip Code

Spouse's Name Place of Employment

Employer Street Address or P.O. Box City State Zip Code

Emergency contact person _____ Phone: _____

Person responsible for account if patient is a minor*

Mother's name: _____ Home Phone: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Business Phone: _____

Mother's employer & address: _____

Father's name: _____ Home Phone: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Business Phone: _____

Father's employer & address: _____

North Georgia Eye Clinic encourages all minors to be accompanied on each visit by parent or guardian.

Treatment of minors

Many times, parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child. I hereby grant to North Georgia Eye Clinic permission to treat my child when they arrive at the office unaccompanied. This may include prescribing medications, ordering laboratory work and performing biopsies. Name: _____ Date: _____

Name of Insured Birthdate Primary Insurance Company Policy Number Group Number

Address Phone Number

Secondary Insurance Company Policy Number Group Number

Address Phone Number

I hereby authorize my insurance benefits to be paid directly to the physician and acknowledge that I am financially responsible for any non-covered services or unpaid balance and any legal fees necessary to collect the unpaid balance. I also authorize my physician to release any information required in processing of these benefits.

Patient's Signature _____

Date _____

NORTH GEORGIA EYE CLINIC AND LASER CENTER
FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file your insurance as a courtesy to you however **YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.**

1. Our office participates with a variety of insurance plans including Medicare and Medicaid. It is your responsibility to:
 - Bring your insurance card at every visit
 - Pay your Co-Payment and / or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept VISA, MasterCard, and Discover.
 - Pay in full for any medical care or service that are not covered by your insurance plan.
2. If you have insurance that we do not participate in our office is happy to file the claim upon request, however payment in full is expected at the time of service.
3. Referrals for HMO, POS, Medicaid or PeachCare: It is your responsibility to bring any required referrals for treatment at or prior to the visit. If you do not have a referral your visit may be rescheduled or you will be financially responsible for the visit.
4. If the patient is a minor (18 years or younger and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at time of service or any remaining balance after insurance pays and bringing insurance card and / or any referrals.
5. If you have questions about your insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member services department. The telephone number should be located on your insurance card.
6. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Late fees will be added on any balance (Insurance or Patient) over 90 days old. A statement fee will be added to billing for services that were due at time of visit.

Signature of Understanding

I have read and understand the above stated financial policy. I accept responsibility for services as outlined above.

Patient or Parent / Guardian if Patient is under 18

Date

**CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT,
TREATMENT AND HEALTH CARE OPERATIONS**

By signing below, you hereby consent for North Georgia Eye Clinic and Laser Center to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

If you want to read the Notice of Privacy Practices for PHI before signing the Consent, please ask for a copy. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for North Georgia Eye Clinic and Laser Center.

You have the right to request that North Georgia Eye Clinic and Laser Center restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. North Georgia Eye Clinic and Laser Center is not required to agree to requested restrictions, however; if North Georgia Eye Clinic and Laser Center agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Do we have permission to:

Leave a message on your answering machine at home? _____ YES _____ NO

Leave a message at your place of employment? _____ YES _____ NO

Discuss your medical condition with any member of your household? _____ YES _____ NO

If yes, whom? _____

Individual Signature

Date

As a personal representative, I have authority to act for the individual because I am the individual's
