Registration : Georgia Vision Center, LLC

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home: / Work: / Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Georgia Vision Center, LLC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Georgia Vision Center, LLC
X		344 Main Street South Hiawassee, GA 30546 Phone: 706-896-3303 Email:

Please attach all pertinent insurance ID cards for photocopying.

Georgia Vision Center

VISION SOURCE

Notice of Privacy Practices Acknowledgement (HIPAA)

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms are subject to change. If we change our notice, you may obtain a copy by writing to our office with your request.

You have the right to request that we restrict how your protected health information is used or released for treatment, payment or health care operations. We are not required to agree to this restriction but, if we do agree, we are bound by our agreement.

By signing this form, you consent to our use of protected health information as described in our notice. You have the right to revoke this consent in writing, with the exception of where we have already made releases in reliance on your prior consent.

Payment Policy

Payment is due at the time of services. As a courtesy, we will file the insurance for you provided you have given us your insurance information at check in and provided our services are covered under your insurance plan. If we are filing your insurance, we will bill you for any charges that the insurance company deems patient responsibility. Please note, with the exception of vision plans which allow for annual visits, most routine eye exams are not covered by medical insurances unless there is a medical diagnosis. If you do not have a vision plan, please be prepared to pay for your exam should it be billed as a routine visit.

There will be a $30.00 charge on all returned checks. Should the account be referred to an attorney or magistrate for collection, the undersigned shall pay all attorney's and collection fees. Your signature following our policies indicates that you understand our payment policy fully.

Assignment of Benefits

I hereby assign and authorize benefits for services rendered to me to be paid directly to Georgia Vision Center as indicated by my signature following the office policies. I understand that verification of insurance benefits is not a guarantee that benefits will be paid. I further understand that my health insurance company may not cover all or part of the medical services rendered and that I am financially responsible for and agree to pay all charges not paid by my health care coverage. I understand that Georgia Vision Center may file my insurance as a courtesy; however, I am ultimately responsible for payment of all services rendered. I authorize the release of medical information required to process the claims for payment of the services rendered. A copy of the assignments shall be considered as valid as the original.

Refraction

Refraction is the test that measures a person's prescription for eyeglasses. It is also used to check or update an old prescription. The refraction helps to determine if your vision condition is an optical condition or possibly a medical condition. Optical conditions include farsightedness, nearsightedness, astigmatism and the inability to focus on near objects that develop with age. Medical conditions may include infections, macular degeneration, glaucoma and cataracts.

This test is usually covered by routine vision plans. However, it is not always covered by health care insurances. It is considered a separate procedure. Medicare does not pay for the refraction. It is considered a non-covered service. Our fee for this procedure is $35.00 payable at the time of service. The only exception is if we are aware that your insurance company has paid for this procedure in the past.

Your signature, following our policies, indicates you understand that in the event the refraction test is considered a non-covered procedure by your insurance company that you will be responsible for the $35.00 charge at the time of service.

_____ _____

Signature of Patient or Responsible Party Date

Georgia Vision Center

VISION SOURCE

Ethnicity/Race

____Hispanic	____American-Indian/Alaska Native	____Middle Eastern
____Not Hispanic	____Asian	____Native Hawaiian or Other Pacific Islander
PREFERRED LANGUAGE	____Black/African American	____White
____English	____East Indian	____Other
____Spanish	____Hispanic or Latino	
Other: _____		

Contact Lens Evaluation/Fitting (if applicable)

The contact lens evaluation/fitting is a separate part of an eye exam. All contact lens patients will need an evaluation yearly if you plan to continue to wear/purchase contact lenses. The evaluation/fitting is not covered by health care coverage except when medically necessary. Routine vision plans however, may have an allowance for the evaluation/fitting as part of the contact lens benefit. The fee for this service is based on lens type and includes a 30 day follow-up. If you have any questions please feel free to ask.

Contact Lens Return/Exchange Policy (if applicable)

Disposable or frequent-replacement contact lenses may be returned only if the boxes have not been opened or written on. Diagnostic/ trial lenses are available for most disposable or frequent replacement lenses. These lenses may be provided free of charge to you for the purpose of making sure the lenses meet your satisfaction before ordering boxes. Should there be any questions or problems with the diagnostic/trial lenses; they should be addressed before opening or writing on the purchased boxes.

Gas permeable contact lenses can be returned or exchanged within 90 days from the initial visit. This 90 day trial period is designed for the purpose of making sure the lenses meet your satisfaction. Should there be any questions or problems with the lenses, they should be addressed within the 90 day trial period. Please note that there will be no refunds or exchanges after the 90 day trial period.

Glasses/Lenses Exchange Policy (if applicable)

All new glasses have a 90 day exchange period from the date of delivery. If glasses are returned due to non-adaptability or patient dissatisfaction within this period, Georgia Vision Center will remake the lenses at no additional charge. However, additional charges may be incurred if the replacement glasses are an upgrade to the original glasses purchased. There are no refunds given under this policy. Any returns due to defective material will be covered under warranty for one year unless specified otherwise.

I have read and understand all of the above policies. I authorize Dr. Joey Arencibia, OD, his associates and technical assistants to provide diagnostic evaluation and treatment.

_____ _____

Signature of Patient or Responsible Party Date