Account #_____

****

*****Co-pays are to be paid at the time service is rendered*****

Athens Eye Doctors & Surgeons, LLC

Patient Registration Form

Name:_____Sex (circle) M F

First Middle Last Nickname

Address:_____City:_____State:_____Zip:_____

Home #: (____)_____Work #: (____)_____Cell #: (____)_____

Marital Status:_____DOB:_____Age:_____Social Security #:_____

Spouse's Name:_____Spouse's DOB:_____Work #: (___)____ _____

Patient's Employer:_____Patient's Occupation:_____

Employer's Address:_____City:_____State:_____Zip:_____

Emergency Contact:_____Phone #: (____)_____

Address:_____City:_____State:_____Zip:_____

Email Address: _____

****

Responsible Party (if other than Patient)

Name:_____Relation to Patient:_____

First Middle Last

Address:_____City:_____State:_____Zip:_____

Home #: (____)_____DOB:_____Social Security #:_____

Employer:_____Employer's Address:_____

Assignment of Benefits, Release of Information, Signature on File

I request payment of authorized Medicare benefits be made on my behalf to Keller, Crymes, and DeMarco, LLC for services furnished me by Keller, Crymes, & DeMarco, LLC. I authorize any holder of medical or other information about me to release to my insurance company, hospitals ,Social Security Administration and CMS or its intermediaries or carriers, any information needed for this related Medicare claim. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

I have had full opportunity to read and consider the contents of the **Notice of Privacy Practices** of Athens Eye Doctors & Surgeons, LLC. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatment, payment activities, and healthcare operations.

Signature:_____Date:_____

Referral Source:_____

****

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ Today's Date _____

Medical Doctor: _____ Cardiologist: _____
If you were referred by a doctor, please list their name: _____

Medical Conditions: (please check all that apply)

☐ Diabetes How Long _____	☐ Heart Attack	☐ Thyroid Disease
☐ High Blood Pressure	☐ Hepatitis	☐ Depression
☐ Heart Disease	☐ Kidney Failure/Dialysis	☐ Asthma
☐ High Cholesterol	☐ Arthritis	☐ COPD
☐ Irregular heart rhythm	☐ Cancer (location)_____	☐ Stroke
☐ Enlarged Prostate (history of)	☐ Other _____	☐ Shingles

Current medications: (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

DRUG ALLERGIES: _____

Past Eye Disease, Eye Surgeries, Head or eye injuries: _____

Surgeries: (***please list all medical surgeries, anywhere on the body and when***)

_____

_____

Did you have any problems with anesthesia? _____ What problem? _____

Family History : Please check any family history for the following conditions:

Disease/Condition	**Relationship to you**			
	Mother	Father	Sibling	Grandparent
Glaucoma	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. YES ____I would prefer to discuss my Social History information with my doctor.

Do you drive? YES _____ NO _____ **Do you smoke?** YES _____NO _____
Do you use smokeless tobacco products? YES _____ NO _____
Do you drink alcohol? YES _____NO _____ **Do you use illegal drugs?** YES _____NO _____
Have you ever been exposed to or infected with (please circle) Gonorrhea, Hepatitis, HIV, Syphilis, or MRSA. **Are you pregnant and/or nursing?** YES _____NO _____**Is there any other information, not covered on this questionnaire that you feel will allow us to better serve your needs?**

_____

_____

Date_____ Name_____

Cataract and Refractive Lens Exchange Questionnaire

The term "cataract" refers to a cloudy lens within the eye. When a cataract is removed, an artificial lens is placed inside the eye to take the place of the human lens that has become the cataract. Occasionally, clear lenses that have not yet developed cataracts are also removed to reduce or eliminate the need for glasses or contacts. If it is determined that surgery is appropriate for you, this questionnaire will help us provide the best treatment for your visual needs. It is important that you understand that many patients still need to wear glasses for some activities after surgery. Please fill this form out completely and give it to the doctor. If you have questions, please let us know and we will assist you with this form.

1. After surgery, would you be interested in seeing well **without glasses** in the following situations?

Distance vision (driving, golf, tennis, other sports, watching TV)

___Prefer no **Distance** glasses. ___ I wouldn't mind wearing **Distance** glasses.

Mid-range vision. **(computer, menus, price tags, cooking, board games, items on a shelf)**

___Prefer no **Mid-range** glasses. ___ I wouldn't mind wearing **Mid-range** glasses.

Near vision (reading books, newspapers, magazines, detailed handwork)

___Prefer no **Near** glasses. ___ I wouldn't mind wearing **Near** glasses.

2. Please check the **single** statement that best describes you in terms of **night vision:**

___ a. Night vision is extremely important to me, and I require the best possible quality night vision.
___ b. I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
___ c. Night vision is not particularly important to me.

3. If you **had** to wear glasses after surgery for one activity, for which activity would you be **most** willing to use glasses? ____**Distance Vision.** ____**Mid-range Vision.** ____**Near Vision.**

4. If you could have good **Distance Vision during the day without glasses**, and good **Near Vision for reading without glasses**, but the compromise was that you might see some **halos or rings** around lights at night, would you like that option? ____Yes ____No

5. If you could have good **Distance vision during the day and night** without glasses, and good **Mid-range Vision** without glasses, but the compromise was that you might need glasses for reading the finest print at near, would you like that option? ____Yes ____No

6. Surgery to reduce or eliminate your dependence upon glasses for **Distance, Mid-range and Near Vision** may be partially covered by insurance if you have a cataract that is covered by insurance. Would you be interested in learning more about this option?

____Yes ____No ____Maybe, it depends on how much is covered by insurance.

7. Please place an "X" on the following scale to describe your personality as best you can:

[----------I----------]
Easy going Perfectionist

Please Sign Here_____

Reference: http://www.crstoday.com/Pages/DellIndex.doc

KELLER, CRYMES, DEMARCO, AND SAMS LLC
dba Athens Eye Doctors & Surgeons, LLC
105 Trinity Place
Athens, GA 30606
706-549-9993
800-962-3547
Fax: 706-549-4047

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____
Name of entity giving this information

to disclose my protected health information (PHI) to _____.
Name of entity receiving this information

This authorization permits _____ to
Name of entity giving this information

disclose __ my entire medical record or __ the following individually identifiable PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.):

_____
_____

The information will be used or disclosed for the following purpose:

_____
_____

If requested by the patient, purpose may be listed as "*at the request of the individual*." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information.

I do not have to sign this authorization in order to receive treatment from Athens Eye Doctors & Surgeons, LLC. I have the right to refuse this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon the authorization. My written revocation must be submitted to HIPAA Coordinator at 105 Trinity Place Athens, GA 30607.

X_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____ _____
Print Name of Legal Guardian Patient's Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

Account #_____

KELLER, CRYMES, DEMARCO, & SAMS, LLC

(dba Athens Eye Doctors and Surgeons, LLC)

OFFICE PAYMENT POLICY

Payment for services is due at the time services are rendered. We accept cash, checks, and major credit cards. As a service to our patients, we are happy to file your insurance claims as long as you provide a current insurance card and accurate information for filing. Please note the following items:

1. Not all services are covered by insurance plans. Non-covered service charges are your responsibility, for example, **refraction** (the process of determining your eyeglass prescription) is **$30.00**.
2. Co-payments and deductibles are due at the time services are rendered. It is unlawful for us to waive co-pays or deductibles.
3. Benefits quoted by your insurance company are not a guarantee of payment. If you are covered by a wellness plan, it is your responsibility to inform our staff of the provisions included in your policy.
4. After 60 days any balance still outstanding on your account, regardless of any insurance claim, becomes your responsibility and we expect payment in full at that time. Should this happen, we would appreciate your contacting your insurance company, as Georgia law requires either payment or a written explanation for nonpayment within 60 days of filing.
5. If you are unable to pay your outstanding balance in full at that time, please call us to arrange monthly payments. You will be required to sign a payment plan agreement.
6. Balances older than 90 days are reviewed and turned over to collections or directed for legal remedy. Subsequently you will be responsible for any collection and/or legal fees.
7. Returned checks are subject to a **$25.00** check fee.
8. We accept Medicare assignment, and file claims for Medicare and Medicaid. If Medicare is your only insurance, you will be responsible for paying the deductible and 20% co-insurance at the conclusion of your visit.

Please remember that you, the patient, are financially responsible for the treatments you receive at Keller, Crymes, DeMarco & Sams LLC. If you have special financial needs, please discuss them with our business office before you leave.

I agree to notify Keller, Crymes, DeMarco & Sams LLC if my insurance company/coverage should be cancelled or changed.

I have read and understand the above policy and agree to abide by these terms.

_____ Date _____

Patient's Signature (or legal guardian)

_____

Patient's Date of Birth

Account #_____

Athens Eye Doctors & Surgeons, LLC
Patient Consent For Use and Disclosure
Of Protected Health Information

I hereby give my consent for Athens Eye Doctors & Surgeons, LLC to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

Athens Eye Doctors & Surgeons, LLC Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Athens Eye Doctors & Surgeons, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HIPAA Coordinator at 105 Trinity Place, Athens, GA 30607.

With this consent, Athens Eye Doctors & Surgeons, LLC 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Athens Eye Doctors & Surgeons, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Athens Eye Doctors & Surgeons, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Athens Eye Doctors & Surgeons, LLC restrict how it uses or discloses my PHI to carry out TPO pursuant to the HIPAA Omnibus Rule of 2013.

By signing this form, I am consenting to Athens Eye Doctors & Surgeons, LLC's use and disclosure of my PHI to carry out TPO and I am acknowledging the Notice of Privacy Practices.

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, Athens Eye Doctors & Surgeons, LLC may decline to provide treatment to me.

I permit Athens Eye Doctors & Surgeons, LLC to release my PHI to: _____

_____

_____

Please list names (Example: spouse, parent, child, etc.)

X_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Patient's Name Print Name of Patient or Legal Guardian

_____
Patient's Date of Birth

ATHENS EYE DOCTORS & SURGEONS, LLC

105 Trinity Place, Athens GA 30607
Contact the Privacy Officer: 706-433-2031
or at paulp@athenseyedoctors.com
www.athenseyedoctors.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes: We do not create or manage a hospital directory. We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

rev: September 20, 2013

This Notice of Privacy Practices applies to the following organizations.

Athens Eye Doctors & Surgeons, LLC
Athens Eye Surgery Center, LLC

Privacy Officer: Paul A. Provenzano, 105 Trinity Place, Athens GA 30607
Contact at 706-433-2031 or paulp@athenseyedoctors.com