WILLIAM C. ACKERMAN, JR., MD
CENTRAEL T. EVANS, M.D.

LEROY W. ROBINSON, III O.D.

ADVANCED EYE CENTER

Date: _____

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Male/Female

Address: _____ Apt. #: _____

City, State, Zip: _____ Social Security #: _____

PREFERRED METHOD OF CONTACT:

( ) Cell/Text #: _____ **Medical Doctor/PCP:** _____

( ) Email address: _____ **Referring Doctor:** _____

( ) Home Phone #: _____ **Pharmacy:** _____

Employer: _____ Work Phone #: _____

Spouse or Parent's Name: _____ Phone #: _____

Person to contact in emergency other than Spouse or Parent

Name: _____ Relationship: _____ Phone# : _____

Person(s) we may discuss your information with _____
Relationship

Home Phone #: _____ Work Phone #: _____

Is this visit work related? _____ Date of Injury: _____
How did accident occur? _____

William C. Ackerman Jr., M.D. • Centrael T. Evans. M.D. • LeRoy W. Robinson, O.D.
625 S. Enota Dr. N.E • Gainesville, GA 30506 • (770) 532-0292

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.

Date: _____

Signed: _____

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.

Date: _____

Signed: _____

Acknowledgement of receipt of Patient Office Policy

In order to give 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.

Date: _____

Signed: _____

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 _____

How did you hear about us? (Circle one above) Family / Friend / Internet / Advertisement / Billboard / Other _____ Medical Doctor _____

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:
_____
_____

MEDICATIONS – List any that you take:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Flomax (Tamsulosin)
Cardura (Doxazosin)
Hytrin (Terazosin)
Minipres (Prazosin)
Uroxatral (Alfuzosin)
Rapaflo (Silodososin)
Jalyn (Dutasteride / Tamsulosin)
Saw Palmetto
Finesteride
Oxytrol (Oxybutynin)
Ditropan (Oxybutynin)
Gelnique (Oxybutynin)

Allergies to Medications: Yes No

If yes, please list:

_____ Reaction: _____

PHARMACY _____

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 02/25/19

Advanced Eye Center
Medical History Questionnaire

Patient Name: _____ Date of Birth: _____

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			_____

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

ADVANCED EYE CENTER

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PATIENT OFFICE POLICY
01/2018

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.

- **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.
- **CONTACT LENS:** 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 care. **You are responsible for your co-pay for the eye exam, as well as, 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 for you provided benefits are available with your particular plan.
- **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, American Express).
- **DISABILITY FORMS:** There is a $15.00 charge for completion of disability forms.
- **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.
- **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 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. Failure to comply may result in a $50.00 fee being charged to your account and you will not be able to reschedule an appointment until that fee has been paid in full.
- **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 appointments 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.
- **REFRACTION FEE: $25.00** A refraction is the process of determining the eye's best corrected vision or need for corrective lenses (glasses or contacts). **Refractions are considered as vision care 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 said insurance you will be reimbursed accordingly.

  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.