

REFERRING PHYSICIAN INFORMATION _____

REFERRING PHYSICIAN NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # () _____ FAX # () _____

PRIMARY CARE PHYSICIAN _____

PRIMARY PHYSICIAN NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # () _____ FAX # () _____

OTHER PHYSICIANS _____

PHYSICIAN NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # () _____ FAX # () _____

PHYSICIAN NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # () _____ FAX # () _____

PHYSICIAN NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # () _____ FAX # () _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

OCULUS

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ D.O.B.: _____

List all Surgeries (Who was the surgeon and what was the date of procedure?):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

Patient Name _____ Date _____ D.O.B. _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency

	MEDICATIONS/ SUPPLEMENTS	STRENGTH	FREQUENCY OF USE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list ALL drug and/or latex allergies.

FINANCIAL POLICY & INSURANCE AGREEMENT

ATLANTA OCULOPLASTIC SURGERY, P.C

1. I agree to furnish *Atlanta Oculoplastic Surgery, P.C.* with a copy of my current health insurance card(s). I also agree to provide explanation of benefits and/or claim forms from my insurance company, when applicable.
2. I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to *Atlanta Oculoplastic Surgery, P.C* for services provided to me by ___ Harvey "Chip" Cole, III, M.D ___ Brent A. Murphy, M.D (please check one)
3. I understand that co-pays are due at the time of service, as required by my insurance company.
4. I agree that I will be responsible for balances applied to my account which are not covered by my health insurance plan.
5. In the event my account is turned over to an outside collection agency, I agree that I will be responsible for a fee of \$25 by *Atlanta Oculoplastic Surgery, P.C* and/or *Specialty Surgery Center, Inc.* as well as any and all attorney fees, court costs, etc.
6. I understand that my account will be charged \$25 when a check I presented for payment is returned marked "Non-sufficient Funds" (NSF). Returned checks over \$500 will be assessed a fee of 5% of the amount of the check.
7. I understand that *Atlanta Oculoplastic Surgery, P.C.* will bill my health insurance company and will refund any overpayment on my account to the appropriate party (insurance company, patient).
8. I understand *Atlanta Oculoplastic Surgery, P.C.* allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
9. I will notify an Insurance Specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the Insurance Specialists at the practice will provide me with assistance in resolving the claim.
10. Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. In the event I am unable to pay my responsibility in full, I will contact the Insurance Specialists to discuss financial arrangements.

I have read, understand and agree to the insurance assignment and financial policies stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with one of the Insurance Specialists at the practice.

Signature of Patient

Date

Please Print Name

Social Security Number