EYE PHYSICIANS AND SURGEONS OF ATHENS, INC.
75 HOSPITAL DR SUITE 110
ATHENS, OH 45710

Welcome to Eye Physicians and Surgeons of Athens, Inc.

Please carefully complete (print clearly) the requested patient information below:

Referring Physician: _____ Date: _____

Patient Information

Legal Name: _____
(Last) (First) (MI)

Preferred Name: _____ Preferred Pronoun: ☐ He ☐ She ☐ They
☐ A pronoun not listed _____

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Phone: _____ Birth Sex: ☐ Male ☐ Female

Social Security #: _____ Ethnicity: _____

Employer Information Race: _____

Employer: _____

Address: _____

Work Phone: _____ Occupation: _____

Insurance Holder Information (Spouse or Parent)

Legal Name: _____
(Last) (First) (MI)

Address: _____

Date of Birth: _____ Phone: _____ Social Security #: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to patient: _____

HIPPA Privacy Policy Acknowledgment

My signature below indicates that I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signature: _____ Date: _____

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Financial Policy, Release of Information, and Assignment of Benefits:

Financial Policy:

We are committed to providing you with the best possible medical care. The charges for medical care are the responsibility of the patient, regardless of insurance coverages. We accept cash, checks, MasterCard, and Visa. We have also agreed to bill many insurance carriers and accept assignment on the allowable charge of insurance benefits. Payment is due at the time of service.

If you have insurance coverage, you are responsible for any co-pay, deductible, co-insurance, or non-covered service. We must have the correct insurance company information in order for you to receive your maximum allowable benefits. You must realize that your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Therefore, you are fully responsible for all charges from the date the services are rendered.

If you do not have insurance coverage, you will be responsible for the charges accrued for medical care. IF immediate payment in full is not feasible, we will be willing to help you with a reasonable payment plan. The plan will be written and signed through our accounting department.

Please notify us immediately of any charges or terminations in your insurance coverage. If an account should become past due, the account may be turned over to a collections agency and interest may be charged. If you have any further questions about our financial policies or concerns regarding your coverage, please do not hesitate to ask.

Release of Information & Assignment of Benefits:

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to Eye Physicians and Surgeons of Athens, Inc. for any medical services furnished to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents or to my insurance carrier any information needed to determine these benefits payable for related services.

I have read the Financial Policy, Release of Information, and Assignment of Benefits information presented above. My signature below indicated that I understand these polices and agree to abide by their provisions.

Signature: _____ Date: _____

Please list below those whom you authorize to discuss your care.

(Name) (relationship) (phone)

_____

_____

_____

_____

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Eye Physicians and Surgeons of Athens, Inc.
75 Hospital Drive Suite 110
Athens, OH
Phone: (740) 592-4461 Fax: (740) 592-5899

Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Pharmacy: _____ Location: _____

Allergies (Please list all allergies below and the reaction experienced.)

_____

_____

_____

_____

Social History

Smoking: ☐ Never smoked
☐ Smokes daily = _____ packs per day
☐ Quit smoking = _____

Alcohol: ☐ Never drank
☐ Drinks daily = _____ drinks per day
☐ Quit drinking = _____

Medications (Please list all of your medications below or we can make a copy of a list of your medications.)

(Name) (Dosage) (Frequency)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Medical History (Please circle below all of the medical conditions that you have or have had in the past.)

Diabetes	Depression/ Anxiety	Thyroid problems
High blood pressure/ hypertension	High cholesterol	Migraines
Asthma	COPD or Emphysema	Stroke
Cancer: _____	Alzheimer's or Dementia	HIV or AIDS
Seasonal allergies	Autoimmune disease: _____	MRSA
Acid reflux	Other: _____	

Surgical History (Please circle below all of the surgeries that you have had in the past.)

Appendix removed	Gallbladder removed	Tonsils removed
Hernia repair	Hysterectomy or Oophorectomy	C-section
Back surgery	Open heart surgery	Heart stents
Joint replacement (knee, hip, shoulder)	Carpal tunnel surgery	Amputation
Pacemaker	Skin cancer removal	Defibrillator
Other: _____		

Review of Systems (Please circle YES or NO if you have any of the following listed below.)

Eye pain	YES	NO
Red eyes	YES	NO
Loss of vision	YES	NO
Elevated blood pressure/ HTN	YES	NO
Elevated blood sugar/ Diabetes	YES	NO
Fever	YES	NO
Weight loss	YES	NO
Dry mouth	YES	NO
Shortness of breath	YES	NO
Upset stomach	YES	NO
Joint pain	YES	NO
Arthritis	YES	NO
Headache	YES	NO
Thyroid abnormalities	YES	NO
Bleeding	YES	NO
Allergies	YES	NO
Depression	YES	NO

Ocular History (Please circle below all of the ocular conditions that you have or have had in the past.)

Cataracts	Macular Degeneration	Glaucoma
Detached Retina	Dry Eye Syndrome	Thyroid Eye Disease
Diabetic Retinopathy	Retinal Hole or Tear	Pseudophakia (cataracts removed)
Double Vision	Uveitis or Iritis	Fuch's

Other: _____

_____

NO SHOW/ MISSED APPOINTMENT POLICY

We, at Eye Physicians and Surgeons, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24 hour notice). You can cancel appointments by calling the following number: 740-592-4461.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call is made/ attempted at least one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours notice: There is a waiting list to see the clinicians at Eye Physicians and Surgeons and, whenever possible, we like to fill canceled spaces to shorten the waiting period for other patients.

2. If less than a 24 hour cancellation is given this will be documented as a "No Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No Show" appointment.

4. After the first "No Show/ Missed" appointment, you will receive a phone call or letter reminding you of our "No Show" policy. Eye Physicians and Surgeons will assist you to reschedule this appointment if needed.

5. If you have a second (2nd) "No Show/ Missed" appointment, you will receive a warning letter from our office and will be assessed a $20.00 no show fee. This fee will need to be paid in full before your appointment can be rescheduled or will be due within 30 days of the missed appointment, whichever comes first. If you fail to pay the fee or contact our office, we will assume that you have chosen to see ophthalmic care elsewhere, and a dismissal from the practice will be considered.

6. If you have three (3) "No Show/ Missed" appointments, then you will receive a second (2nd) $20.00 no show fee assessment and a dismissal from the practice will be issued.
*** You will be notified by letter if the dismissal from our practice is approved by the providers.**

I have read and understand Eye Physicians and Surgeons No Show/ Missed Appointment Policy and understand my responsibility to plan appointments accordingly and to notify Eye Physicians and Surgeons appropriately if I have any difficulty keeping my appointments.

_____	_____	_____
Patient Name (printed)	Date of Birth	Date
_____		_____
Patient Signature or Parent/ Guardian if minor		Relationship to Patient
_____		_____
Staff Signature		Date