Children's Eye Institute of Savannah

340 Eisenhower Dr., Bldg 1400, Suite A
Savannah, GA 31406

(912) 353-1001
fax (912) 353-1026

PERSONAL INFORMATION

First Name	M.I.	Last Name	Female / Male	Social Security #	Date of Birth	Age

Street Address	Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Other ____

City	State	Zip Code	Home Phone	Work Phone	Cell Phone

Patient Employer	Patient Profession	Department

Name of Spouse	Spouse Employer	Spouse Contact #

Emergency Contact	Emergency Contact Employer	Emergency Contact #

Referring Physician

FINANCIAL INFORMATION

Person Financially Responsible for Services Rendered	Relationship to Patient

Street Address	City	State	Zip Code	Home Phone	Cell Phone

Employer	City	State	Zip Code	Department	Work Phone

INSURANCE INFORMATION

Primary Insurance Information

Name of Insurance	Paper Claims Mailing Address of Insurance		Contact #

Name of Subscriber	Subscriber's Relationship to Patient	Subscriber's Date of Birth

Policy/ID #	Group #	Effective Date of Coverage	Specialist Copayment

Secondary Insurance Information

Name of Insurance	Paper Claims Mailing Address of Insurance		Contact #

Name of Subscriber	Subscriber's Relationship to Patient	Subscriber's Date of Birth

Policy/ID #	Group #	Effective Date of Coverage	Specialist Copayment

AUTHORIZATION TO RELEASE INFORMATION TO INSURER: I hereby authorize Children's Eye Institute of Savannah to release to my insurer information acquired in the course of my treatment.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Children's Eye Institute of Savannah for the surgical and/or medical benefits for any medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I understand my insurance will be filed as a courtesy only. I understand that should my insurance not respond in a timely manner that I will be billed for the balance due. I understand that non covered services by my insurance will be my responsibility and I will be billed for the balance due. Any copays, coinsurance, deductibles, and noncovered services must be paid at time ofservice. If noninsured payment must be paid in full at time of service. I understand that all balances must be paid within 30 days of first statement; if not paid within 30 days there will be a finance charge added to the balance. I further understand that any balances turned over to an outside collection agency will be subject to additional collection fees.

Signature of insured person, parent, or guardian_____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION: I hereby authorize Children's Eye Institute of Savannah to share any personal health information with the following persons:

Name_____ Relationship to Patient_____ Contact #_____

Name_____ Relationship to Patient_____ Contact #_____

Name_____ Relationship to Patient_____ Contact #_____

Signature of patient, parent, or guardian_____

PATIENT ACKNOWLEDGMENT OF UNDERSTANDING
OF
CHILDREN'S EYE INSTITUTE OF SAVANNAH'S PRIVACY PRACTICES

Patient's name:_____ Date of birth:_____

SSN:_____ Previous name (If applicable)_____

I understand that the patient's health information is private and confidential. I understand that Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua D. Visalli, OD work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is available in our office. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD may update this Acknowledgment and "Notice of Privacy Practices." If I ask, Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD will provide me with the most current "Notice of Privacy Practices."

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of Children's Eye Institute of Savannah/John M. DeVaro, MD and Joshua Visalli, OD's "Notice of Privacy Practices."

_____

Date Time

Relationship to patient: ____Self ____Parent ____Legal Guardian ____Personal Representative:_____

Children's Eye Institute of Savannah John M. DeVaro, MD
Pediatric Ophthalmology
Strabismus Surgery

Refraction Service and Fee

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for eyeglass. Contact lens fitting requires additional measurements.

Most medical insurance plans do NOT cover routine refractions and allow that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for refraction is $30.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Damage to office and office equipment

Children are to be supervised by a parent or guardian at all times. If any damage is done to the office, including the waiting room and restroom, you may be held responsible for its repair.

If any office equipment is broken or damaged by someone under your supervision, you may be held responsible for the cost of repair to the equipment.

Cancellation Notice

Our office requires at least a 48 hours notice for any appointments that need to be cancelled or rescheduled. If you do not call by then and miss your scheduled appointment, you will be considered a no show for that appointment.

If you miss more than two scheduled appointments, you may be discharged from the practice and asked to follow up elsewhere.

Patient Acknowledgement

I have read and understand the above office policies for Children's Eye Institute.

_____ _____
Patient's Name Date

_____
Signature of patient or guardian

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▲ DATE (MM / DD / YY) ▲ REFERRED BY ▲ BIRTH DATE

▲ PATIENT'S NAME ▲ SEX ▲ AGE

▲ ADDRESS ▲ PHONE (H)

▲ EMPLOYER ▲ OCCUPATION ▲ PHONE (W)

▲ SOC. SEC. NO. ▲ PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. **Do you have a history of premature birth?** ❑ Yes ❑ No
   *If YES: Birth Wt.*_____ *Gest. Age* _____
2. **Have you ever been treated for any medical conditions** (e.g. diabetes, high blood pressure, arthritis, etc.)?
   ❑ Yes ❑ No *If YES, please explain:*_____
3. **Have you ever had any eye disease** (e.g. glaucoma, cataracts, wandering or "lazy" eye, retinal detachment)?
   ❑ Yes ❑ No *If YES, please explain:*_____
4. **Have you ever had any kind of surgery?**
   ❑ Yes ❑ No *If YES, please list date and reason:*_____
5. **Have you ever been hospitalized?**
   ❑ Yes ❑ No *If YES, please list date and reason:*_____
6. **Do you take any medications?**
   ❑ Yes ❑ No *If YES, please list:*_____

   Do you take any eye medications?
   ❑ Yes ❑ No *If YES, please list:*_____
7. **Do you have any drug or food allergies?**
   ❑ Yes ❑ No *If YES, please list:*_____

Review of Systems

	Yes	No	*If YES, please explain:*
Do you currently have any of the following problems?			
Chronic fever, unexpected weight loss / gain, fatigue	❑	❑	
Ear / nose / throat problems *(e.g. hearing loss, sinus problems, sore throat)*	❑	❑	
Heart problems *(e.g. chest pain, irregular heart beat)*	❑	❑	
Respiratory problems *(e.g. shortness of breath, wheezing, coughing)*	❑	❑	
Gastrointestinal problems *(e.g. heartburn, abdominal pain, diarrhea, vomiting)*	❑	❑	
Urinary problems *(e.g. pain or discomfort, blood in urine)*	❑	❑	
Skin problems *(e.g. rashes, excessive dryness)*	❑	❑	
Musculoskeletal problems *(e.g. muscle aches, joint pain, swollen joints)*	❑	❑	
Neurologic problems *(e.g. numbness, weakness, headaches, paralysis)*	❑	❑	
Psychiatric problems *(e.g. depression, anxiety)*	❑	❑	

8. **Do any medical or eye diseases run in your family** (e.g. diabetes, high blood pressure, cancer, glaucoma, mascular degeneration)?
   ❑ Yes ❑ No *If YES, please list:*_____
9. **Do you smoke?** *If YES, how much?*_____ **Do you drink alcohol?** *If YES, how much?*_____

▲ COMMENTS

▲ M.D. SIGNATURE ▲ DATE