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	Social Security #	Date of Birth	Age

Birth Sex	Preferred Pronouns

Street Address	Marital Status (If Applicable): Single ____ Married ____ Divorced ____ Widowed ____ Other ____

City	State	Zip Code	Home Phone	Work Phone	Cell Phone

Name of Parent	Parent Employer	Parent Contact #

Emergency Contact	Emergency Contact Employer	Emergency Contact #

Referring Physician	Best Email Address

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_____

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 the 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 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 the 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. A Cancellation Fee may be charged.

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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(912) 353-1001 Fax (912) 353-1026

PATIENT NAME: _____ **CHART NO.:** _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: Your carrier does not pay for everything, even some services that you or your health care provider have good reason to think that you need. Your insurance carrier may only pay for some services once per year. If it is determined by the medical staff that one of these exams is required more often, then you will have to pay for it out-of-pocket.

		REASON CARRIER MAY NOT PAY	ESTIMATED COST
Sensorimotor Exam	**92060**	**Limited to one per 12 months**	**$49.31**
External Ocular Photo	**92285**	**Non-covered service**	**$19.44**
Visual Field Exam	**92083**	**Limited to one per 12 months**	**$50.76**
OCT scan Optic Nerve	**92133**	**Limited to one per 12 months**	**$38.01**
OCT scan Retina	**92134**	**Limited to one per 12 months**	**$38.16**
Refraction	**92015**	**Non-covered service**	**$30.00**

What you need to do now:

- Read this notice, so that you can make an informed decision about your care.
- Ask us any questions that you may have after you have finished reading.
- Choose an option below about whether to receive the service.

Note: If you choose Option 1, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

_____ **OPTION 1:** I will pay for the service above as determined by my medical provider. I know I will be required to pay now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment and no refund will be issued. If my insurance does pay I understand I will be reimbursed any payments I made to the Children's Eye Institute for this service.

_____ **OPTION 2:** I do not want the service. I understand with this choice I am not responsible for payment, but I may not be receiving medically necessary services, and I cannot appeal to my insurance.

This notice gives our opinion, not an official insurance decision. If you have any other questions on this notice, please ask us.

Signing below means that you understand this notice:

Sign: _____ **Date:** _____