EYE SPECIALISTS OF GEORGIA
PLEASE ANSWER ALL QUESTIONS

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ AGE _____ SEX _____ SS#. _____

MARRIED SINGLE DIVORCE WIDOWED

ADDRESS _____ CITY _____ STATE. _____ ZIP _____

PHONE (HOME) _____ PHONE (CELL) _____

EMAIL ADDRESS _____

EMERGENCY CONTACT PERSON _____ PHONE _____

GOVERNMENT REQUIREMENTS

- PRIMARY LANGUAGE _____
- RACE _____
- ETHNICITY _____
- MOTHER'S MAIDEN _____ BIRTH STATE _____

EMPLOYER _____ ADDRESS _____
POSITION PHONE _____

PRIMARY CARE PHYSICIAN/ INTERNIST _____
ADDRESS _____ PHONE _____
REFERRED BY _____ PHONE _____

IF PATIENT IS MINOR PLEASE COMPLETE THE FOLLOWING INFORMATION

PARENT/ GUARDIAN'S NAME _____ SS# _____
ADDRESS (IF DIFFERENT) _____ PHONE _____

I UNDERSTAND THAT ALL OFFICE VISITS ARE TO BE PAID IN FULL AT TIME OF SERVICE: *THAT I AM RESPONSIBLE FOR MY BILL, THAT CHARGES WILL BE EXPLAINED TO ME*

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN WHEN NECESSARY FOR HIM TO FILE A CLAIM, AND RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

DATE _____ SIGNED _____
PARENT OR GUARDIAN _____

A.M. NASSAR, M.D.
DAO NGUYEN, O.D.
EYE SPECIALISTS OF GEORGIA

777 CLEVELAND AVENUE, SUITE 616
ATLANTA, GEORGIA 30315
(404)766-6268

6524 PROFESSIONAL PLACE
RIVERDALE, GEORGIA 30274
(770)996-2096

INSURANCE AND BILLING POLICIES

Due to recent confusion with insurance and billing policies in our office, it is important that we clarify our policies so that all of our patients will understand our filing procedures.

We participate in a great number of insurance plans, many of which have different benefits for the different companies, which they insure. Although familiar with the plans in general, it is every patient's responsibility to be knowledgeable about their own plan through the information provided by their employer or insurance company.

We file insurance without collecting the charges at the time of service (except for your co-pay, if any) as a courtesy to our patients. When the explanation of benefits is processed back to us, there will be a reimbursement for the visits and / or procedures, or the insurance will be denied, stating a specific reason for the denial. Once the insurance company has denied benefits, for whatever reason, we bill the patient and the charges become their responsibility to pay. Of course, we try to take care of the errors, which are obvious and easily corrected with the insurance company before we bill the patient.

Please understand that due to our patient load and the complex nature of insurance, we have neither the staff nor the resources needed to pursue all of our patient's insurance problems, nor can we refile a claim unless we made the error on the original claim.

If you should receive a bill from us, we will be happy to answer any questions concerning the statement or set up a payment plan that is convenient for you.

Many of our insurance companies require a co-pay for the office visit. These co-pays are due at the time of service, so please come prepared to make your co-pay at the time of your appointment.

We appreciate your cooperation with our insurance and billing policies and hope this will work to the benefit of all of our patients.

Patient's Name _____ _Date_____

(please print)

Signature _____

Parent/Guardian Signature _____

Your signing this certifies that you have read and understood this information and that you promise to abide by our insurance and billing policies.

Eye Specialists of Georgia Medical History Form

Last Eye Exam _____

List all current
Medications _____

Allergies and
Reactions _____

_____ Have you ever been treated for the following? (Describe)_

Y/N Cataract
Y/N Glaucoma
Y/N Eye Trauma or Injury _____
Y/N Cornea problem
Y/N Retinal Tear *I* Detachment
Y/N Macular Degeneration
Y/N Diabetic Eye Disease
Y/N Perfect vision in both eyes in youth
Y/N High Cholesterol

Other _____

_____

YIN High Blood Pressure _____ yrs
YIN Diabetes _____yrs
YIN Heart attack
YIN Heart disease
YIN Lung disease
YIN Neurologic :Stroke
YIN Kidney disease */* kidney stone */* Liver disease */* Hepatitis
YIN Aids / IDV
YIN Abnormal bleeding
YIN Arthritis
YIN Gastrointestinal Problems */* Acid Reflux
YIN Recent Significant weight loss */* gain

General Surgery ? type and date

_____

Smoker: YIN___ Packs/day Alcohol YIN Drugs YIN
Family History: High B/P, Diabetes, Glaucoma, Macular Degeneration, Retinal Detachment

Eye Specialists of Georgia's
Written Acknowledgement Form
Dr. Ahmed Nassar, M.D., Dr. Xuandao Nguyen, O.D.
& Dr. Bo King, O.D.

FOR PATIENT:

(PLEASE INITIAL ON THE LINE OF THE SELECTION THAT APPLIES)

I am a patient of Eye Specialists of Georgia I hereby acknowledge that_____I have requested a personal copy and have read Eye Specialists of Georgia's Notice of Privacy Practices or_____I have read the office copy and decline receiving a personal copy at this time of Eye Specialists of Georgia's Notice of Privacy Practices.

FOR MINOR:

(PLEASE INITIAL ON THE LINE OF THE SELECTION THAT APPLIES)

I am a parent or legal guardian of_____.I hereby acknowledge that_____I have requested a personal copy and have read Eye Specialists of Georgia's Notice of Privacy Practices or_____I have read the office copy and decline receiving a personal copy at this time of Eye Specialists of Georgia's Notice of Privacy Practices on behalf of the patient.

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

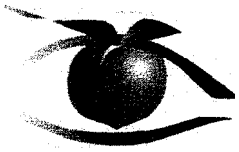
Relationship to Patient:___Parent____Legal Guardian Other:___ Signature:_____

Date: _____

I acknowledge that if I allow my Protected Health Information ("PID") to be issued to anyone other than those listed in Eye Specialists of Georgia's Notice of Privacy Practices I will tint have to provide the practice with written authorization.

_____ _____

Print Patient Name Patient, Parent or Guardian Signature and Date



EYE SPECIALISTS OF GEORGIA

.JOSEPH A. MANNO, ID, M.D. **AHMED M. NASSAR, M.D., M.S.** **XUANDAO NGUYEN, O.D.**

INFORMATION REGARDING DILATING EYE **DROPS**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Nassar / Dr. Nguyen and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

777 Cleveland Avenue, Suite 616
Atlanta, GA 30315
Telephone (404) 766-6268
Fax (404) 766-6260

www .EyeSpecialistsofGeorgia.com

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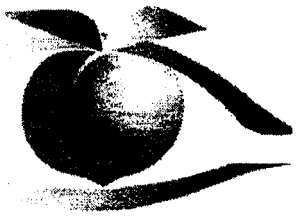
Revi - 2093



EYE SPECIALISTS OF GEORGIA

Effective February 01, 2012

No Show Policy

In an effort to better serve our patients, monitor clinic flow and efficiently staff our office we are implementing a No Show Policy. We will be tracking scheduled appointments for patients who fail to keep their scheduled appointment or do not provide 24 hour notice of cancellation, after 3 violations patients will be released from the practice. In the event of an emergency, if notice cannot be given, a one-time "Grace" may be granted at the discretion of the office. Due to an increase in No Show appointments it has become necessary to implement this change so that we can staff our office sufficiently to ensure that we see our patients in a timely manner. We make it our priority to provide exceptional care and we ask that consideration is made when booking an appointment so that we may continue to do so. We thank you in advance for your cooperation and understanding.

Thank you,
Eye Specialists of Georgia

_____ _____

Patient Signature Date

_____

Account Number

1st Offense- Grace Period

2nd Offense- Letter Mailed to Patient to Make Aware of Next Step

3rd Offense- Patient Released from the Practice