Wood Vision Center

This form must be completed in full at every visit.

PATIENT INFORMATION

Last Name: _____ First Name: _____Middle:_____

Address: _____ City: _____State: _____Zip:_____

Date of Birth:_____/_____/_____ Email: _____@_____

SSN: ____-____-_____(must have at least last 4 numbers for insurance claims) Sex:__Female __Male

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____-_____

Communication Preference: ____Telephone ____Text ____Email ____Postal

Please list below individuals with whom we can communicate with about your medical history:

Name: _____ Relation: _____Phone_____

Name: _____ Relation: _____Phone_____

INSURANCE INFORMATION

Vision Insurance

Name of Insurance:_____

Member ID: _____

Insured's Name: _____

Insured's DOB: _____

SSN of Insured: _____

Medical Insurance

Name of Insurance: _____

Member ID: _____

Insured's Name: _____

Insured's DOB: _____

SSN of Insured: _____

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

MEDICAL INFORMATION:

Vision Information:

Do you wear:___Glasses ___Contacts If yes to contacts, additional fee applies for contact lens evaluation. First time contact lens wearers must have insertion & removal training $45.

Are you having any vision problems today? (i.e. blurred vision, itchy, soreness, etc.) ___NO ___YES
(if yes, please describe)

Have you ever had any eye disease, eye infection, surgery, or injury? ____NO ____YES
(if yes, please describe)

Social History:

Are you a smoker: __YES __NO __USED TO BE
Do you regularly drink alcohol: ___YES ___NO

Family Ocular History: (if yes put who in your family has had this disease)

Macular Degeneration NO YES Whom: _____
Glaucoma NO YES Whom: _____
Cataracts NO YES Whom: _____
Other: _____

Personal Medical History:

Do you have any problems in the following areas? If yes, please explain:

Cardiovascular NO YES _____
Endocrine NO YES _____
Gastrointestinal NO YES _____
Genitourinary NO YES _____
Head NO YES _____
Immunology NO YES _____
Lymphatic NO YES _____
Muscular/Skeleton NO YES _____
Neurological NO YES _____
Psychiatric NO YES _____
Respiratory NO YES _____
Skin NO YES _____

Please list any other diagnoses that you may have:

_____

Are you currently taking or do you have any allergies to medications? _____YES _____NO
If yes please list below.

Current Medications	Allergies: Medication and reaction

Signature: _____ Date: _____

Wood Vision Center

Dr. James Wood Dr. Susan Wood

428 West Highland Ave
Monroe, GA 30655
Ph) 770-267-2573
F) 770-267-6751
woodvisionmonroe.com

We pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the Optomap® Retinal Exam on all of our patients.** The Optomap allows our doctors to capture an image of the back of your eye where potential vision threatening diseases can be found. This includes **diabetes, glaucoma, certain types of cancer, retinal tears, and cardiovascular issues.**

Also, you will not need to be dilated after the Optomap is captured.

When reviewed, the scan becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **The Doctor prescribes the Optomap Retinal Exam once per year for all patients.**

As part of your pre-test work up, we will capture Optomap® images for review with the doctors during your examination today. There is a $39 co-pay for the Optomap with your vision insurance. Any questions you have about the Optomap® Retinal Exam can be directed to doctor when they review the images with you during your exam.

I have read and understand this document:

Sign: _____ Date: _____

optomap®
ultra-widefield retinal imaging

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Our Privacy Notice

Your Right to Know

As part of the Health Insurance Portability & Accountability Act of 1998 (HIPAA), you have the right to know what we do with the personal and confidential information we collect about you in the normal course of our examination procedures and discussions, as well as written information, the processing and administering of your insurance programs, if you have insurance to assist in paying for your visual needs.

Because we value the integrity of our patient relationships, we want to assure you that we are properly safeguarding this important information.

Personal Information We Collect

We need accurate, current health information and testing so that we can determine your needs and provide products to meet your specific needs and treatments.

We may collect information from third parties, which may include insurance agencies or health care providers you may have records with. None of these will be sought without your permission.

Appointment Reminders/Notifications

We may call, write, text, or email you to notify you of examinations due, appointment confirmation, order status, or services available at our office. Unless you tell us otherwise, we will mail you an appointment reminder and/or call you at the number(s) you have given us. We may leave you a message if you are not available.

Information We May Disclose

We may share your health information on a confidential basis only with authorized employees, representatives, and third parties whose services are required to complete the picture of your visual, and, sometimes, physical health.

We will not disclose any non-public personal information about you or any of our patients except as authorized by law, or unless authorized by you. Any changes in our Notice of Privacy Practices will be posted in our office and on our office website.

Protection Of Your Information

Reasonable care will be taken to keep pertinent records current, complete, and accurate. If you see any inaccuracy in your information we would appreciate your assistance in making corrections by contacting us.

We will protect all information collected about you, and we will restrict access to your non-public personal information by maintaining physical, electronic, and procedural safeguards. We will restrict access to protected data only to individuals who must use it in the performance of their job-related duties. Employees who violate our Privacy Policy will be subject to disciplinary action, which may include termination.

If you have questions or concerns about our Privacy Policy, please contact us at our offices as listed above.

I have read the Privacy Policy and agree with its principles.

Signed:_____ Date:_____.

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About Your Insurance

There are two types of health insurance that can help pay for your eye care services and products. You may have one (or both) and our practice may accept both.

1. **Vision Care Plans** (such as VSP, EyeMed, Spectera etc.).Vision Care Plans only cover "routine" vision exams and often provide a contribution towards eyeglasses or contact lenses. vision plans over cover a basic screening for eye disease. They do not cover diagnosis management or treatment of eye diseases.
2. **Medical Health Insurance** (such as BCBS, United Healthcare, Medicare, etc.)- Medical Health Insurance may be used if you have eye health problems (e.g dry eyes, itching, floaters, cataracts, glaucoma, etc.) or systemic health problems that have ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history. Medical insurance rarely covers the refraction (the testing to determine your eyeglass prescription). Our current fee for refraction is **$39**.

If you have both plans it may be necessary for us to bill some services to one plan and other services to another. We will do this in the best way to minimize your out of pocket expenses.

We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, you are responsible for any unpaid deductibles, co-pays, or non-covered services as allowed by insurance contract.

If we do not participate with your particular plan, you will pay our usual and customary fees at the time of services and you may file with your insurance to get reimbursed for utilizing our office as an out-of-network provider.

We appreciate your confidence and trust in allowing us to serve you! To help serve you best, it is the patient's responsibility to inform us what plans you have before your appointment.

I have read and agree with these policies.

Signature:_____Date:_____

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FINANCIAL POLICY

1. **PAYMENT** for all professional services is due at the time services are provided.
2. **INSURANCE** companies do not pay 100% of all procedures. If you owe a balance after a claim is filed with your insurance company, a statement will be sent to you. Deductibles, co-payments, and non-covered benefits must be considered. **Benefits are not determined by our office. It is the responsibility of the patient to know his/her benefits. If incorrect or expired insurance information is provided, the patient will assume full financial responsibility.**
3. **RETURNED CHECKS** will incur a $30 service charge.
4. **NO-SHOW FEE** of $25 will be charged for all appointments not cancelled within 24 hours.
5. **ALL SATURDAY APPOINTMENTS** require a $25 refundable deposit.
6. **REFRACTION** is the process of determining the need for corrective eyeglass or contact lenses and is necessary to write a prescription. Most medical insurance plans, including Medicare, do NOT cover routine refractions or routing examinations. The fee for a refraction is $39 and is collected at the time of service in addition to your medical plan co-payment. If you have a separate vision plan the refraction is likely covered.
7. **EYEWEAR and CONTACT LENSES** are special order items and once ordered cannot be cancelled. ALL SALES ARE FINAL, NO RETURNS/REFUNDS, exchanges must be made within 30 days of purchase. Frames and contact lenses are subject to a 20% restocking fee and eyewear lenses have a 50% restocking fee.

By signing below I acknowledge that I have read, understand, and accept this Financial Policy.

Signature of patient or legal guardian:_____ Date:_____

Patient's printed name:_____