**GLENN S. SHEAR, M.D. P.C.**
**KEVIN S. FREEMAN, M.D.**
OPHTHALMOLOGY

SUITE 114
33 S.W. UPPER RIVERDALE ROAD
RIVERDALE, GEORGIA 30274
770-991-1624 •FAX 770-991-9206

SUITE D
255 CORPORATE CENTER DRIVE
STOCKBRIDGE, GEORGIA 30281
770-474-7761 • FAX 770-474-6345

To our new patient:

Providing you with excellent care is our primary concern here at Glenn S. Shear, M.D. P.C.

Complete eye exams can take 1-2 hours and require dilation of the pupil. However, some exams are more complex and may take longer. We ask that you please plan the day of your appointment with that in mind. Dilation of the pupils can last for several hours and can make driving difficult. If you don't feel comfortable driving, please make arrangements ahead of time.

Our office understands that sometimes "life happens" preventing you from being on time to your appointment. We give our patients a 15 minute grace period to arrive for your appointment time. Patients who arrive after their 15 minute grace period may either reschedule for a different day or if possible we can try to see you as a "work-in." If we are able to see you as a work-in after your appointment time, you need to consider the wait time for work-ins are sometimes considerably longer than those with appointments.

**Please bring the following with you to your appointment:**

- ID
- Insurance card(s)
- New patient paperwork completed
- Glasses (if you wear them)
- Contact lens boxes (if you wear/have them)
- Complete list of all medications you are currently taking (proper name, dosage, how many times of the day you take it, etc.)
- Any referral forms required
- Eye drops (if you use them bring the bottles with you)

***If you have a co-pay, co-insurance or deductible your payment will be required at the time of service. ***

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# Patient Communication Form

We are in the process of implementing a new appointment reminder and patient communication system for our practice. Please help us make sure we have the most current contact information for your account.

By providing your contact information below, you are granting permission to be contacted via those communication channels. Your information will not be abused and will only be used to contact you regarding your care. Example communications include appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

Patient Name _____ Home Phone _____

Name of Legal Guardian _____Cell Phone _____

Address _____Email _____

_____

When possible I prefer to be contacted via □ Phone Call □ Text □ Email □ Mail

Please list any other minors or family members for which this same contact information applies:

_____ _____

_____ _____

_____ _____

**I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone my limited protected health information, and to leave a message on my voicemail system or answering machine.**

Signature: _____ Date: _____

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## PATIENT REGISTRATION

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

| PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL) | PATIENT DATE OF BIRTH | | |
|---|---|---|---|
| PATIENT PREFERRED NAME | LANGUAGE | RACE | ETHNICITY |

| ADDRESS | CITY, STATE | ZIP | HOME PHONE |
|---|---|---|---|

| CELL PHONE | PATIENT SSN | PATIENT GENDER ❑ Male ❑ Female | MARITAL STATUS ❑ Single ❑ Married ❑ Other_____ |
|---|---|---|---|

| PATIENT EMPLOYER NAME | PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP) | EMPLOYER PHONE |
|---|---|---|

**INSURED/RESPONSIBLE PARTY INFORMATION (Skip if self)** | RELATION TO PATIENT: ❑self ❑spouse ❑parent ❑guardian

| NAME (FIRST -- LAST -- MIDDLE INITIAL) | ADDRESS (if different from patient) |
|---|---|

| HOME PHONE | WORK PHONE | SSN | BIRTH DATE | EMPLOYER |
|---|---|---|---|---|

**INSURANCE INFORMATION (Skip if you brought insurance cards with you)**

| PRIMARY INSURANCE NAME | ADDRESS (STREET - CITY - STATE - ZIP) | PHONE |
|---|---|---|

| GROUP NUMBER | ID NUMBER | EMPLOYER | EMPLOYER PHONE |
|---|---|---|---|

| SECONDARY INSURANCE NAME | ADDRESS (STREET - CITY - STATE - ZIP) | PHONE |
|---|---|---|

| GROUP NUMBER | ID NUMBER | EMPLOYER | EMPLOYER PHONE |
|---|---|---|---|

| PRIMARY DOCTOR/FAMILY DOCTOR | REFFERING DOCTOR | |
|---|---|---|
| IN CASE OF EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER |

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

| SIGNATURE (Patient or, if minor Signature of parent or guardian) | DATE |
|---|---|

**RELEASE OF INFORMATION**

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party.
- The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE | EMAIL |
|---|---|---|
| IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT | SIGNATURE OF WITNESS (Optional): | |

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# OFFICE POLICIES

## Payment Policy

**Payment is expected at the time services are rendered unless prior arrangements have been made with the office. We accept cash, check, Visa, MasterCard & Discover. We do not accept insurance as a method of payment.**

**Providing we are contracted with your insurance company, we will file your claim for you. In the event your insurance deems all or part of our charges non-payable, you will be responsible for those charges. To avoid misunderstandings, our business manager invites early discussion of financial problems or questions regarding fees or payments from insurance carriers. If we are contracted with your insurance, we will call and obtain benefits while you are in the office. You will be responsible for any of the charges that insurance will not cover at the time the service is rendered.**

**We cannot accept the responsibility of negotiating claims with the insurance company or any other persons. The patient is responsible for payment of his or her medical care within a reasonable time, regardless of the status of the claim. Reduction of rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.**

**If you prefer to file your own insurance, fees are payable at the time services are rendered.**

## Office Policy

**Our office works on an appointment schedule. Appointment times are given according to what is available and the type of treatment a patient is to receive. Therefore, it is imperative that you keep all scheduled appointments.**

**Please call our office if you are unable to keep your appointment.**

_____ _____
Signature of Patient or Legal Guardian | Patient's Name

_____ _____
Print Name of Patient or Legal Guardian | Date

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## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Glenn S. Shear, M.D. P.C. to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO).** Glenn S. Shear, M.D. P.C.'s Notice of Privacy provides a more complete description of such uses and disclosures.

- With this consent, Glenn S. Shear, M.D. P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as; (1) Appointment reminders with the physician name, appointment date and time, and our telephone number, (2) Insurance items, (3) Any calls pertaining to my clinical care, including laboratory results among others.
  AGREE _____ DISAGREE _____

- With the consent, Glenn S. Shear, M.D. P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
  AGREE _____ DISAGREE _____

- I have the right to request that Glenn S. Shear, M.D. P.C. restrict how it uses or discloses my PHI and TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.
  AGREE _____ DISAGREE _____

- We have your permission to speak to the following individual(s) **regarding your PHI:**

  _____ _____

  _____ _____

A notice of Privacy Practices is posted in our lobby; however, you may request a copy from the receptionist.

By signing this form, I am consenting to Glenn S. Shear, M.D. P.C.'s use and disclosure of my PHI and TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Glenn S. Shear, M.D. P.C. may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date

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# Dilation Consent Form:

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish or goal, it is essential to dilate the pupils of you eyes. This will require placing drops in your eyes, which will enlarge the pupils and allow us to view the inside of your eye, also known as the Retinal New Tissue.

As with any medications, there are some side effects of the drops that are used to dilate the pupil: sensitivity to light and blurred vision (in most cases the distance vision will be unaffected.) The side effects usually last several hours but rarely last as long as 24 hours.

A dilation is an integral part of an eye examination process. We require your consent in understanding that during today's exam, the patient will be dilated and is responsible for obtaining a pair of solar shields that the office has provided near the exits of the exam area.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date

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# Glasses/Contact Lenses:

A **refraction** is a specific test the doctor performs during an eye examination to determine the prescription for glasses or contacts. If the test/refraction is not performed, we cannot provide a prescription for corrective lenses.

*Most* insurance plans **DO NOT PAY** for the refraction, and should you choose to add the refraction to your examination, there will be a $50.00 surcharge at the time of service, *in addition to your co-payment or any other non-covered fees* (i.e. contact lens fitting exam). With this $50.00 surcharge, you are not paying for the written prescription itself, but for the actual **test** performed in order to determine the prescription.

If a refraction is not performed, we cannot provide you with a prescription for glasses or contact lenses.

A refraction is a very important part of an eye examination if you require corrective lenses. We truly wish that all insurance plans considered this a covered expense. We appreciate your understanding in this matter.

____ YES, I want to be tested for a glasses/contact lens prescription.

____ NO, I do not want to be tested for a glasses/contact lens prescription.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date

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# Pharmacy Information

**Patient Name:** _____

**Patient Email:** _____

**Pharmacy Name:** _____

**Pharmacy Address:** _____

_____

_____

**Pharmacy Number:** _____