Atlanta Ophthalmology
Associates, P.C.
404-252-1194
aoaeye.com

The staff and physicians at Atlanta Ophthalmology Associates (AOA) would like to welcome you to our practice. It is our goal to make every visit to our office pleasurable and productive.

Please take a moment to read and get acquainted with our office and what to expect during your exam.

Your examination will be completed in several steps. Our certified ophthalmic technicians will perform multiple tests followed by a complete ocular health examination with your doctor. If necessary, further specialized testing may be done. Your doctor will then discuss the findings and recommendations with you.

Listed below are some very important pieces of information about your eye examination:

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services you receive in our office.
- Please present all insurance cards at check-in and **inform check-in if your visit is routine or medical**.
- Our fee for a **routine eye exam** ranges from $160 - $235. This fee includes a complete ocular health examination and a glasses refraction.
- **Contact lens patients** require additional testing which is **NOT** included in a routine eye exam. There is an annual contact lens examination fee that will be decided by your doctor at the time of your exam, which could range from $40 - $500 depending on the complexity of your fit. The ***typical fee*** for an established contact lens wearer who is not changing the type of lens you wear is around $40 - $70.
- **If you are scheduled for a medical exam, for example a cataract check or you have any other type of medical diagnosis; this exam is usually covered by your medical insurance.** You will be responsible for your co-pay, co-insurance and/or deductible. If you would like us to check your glasses or contact prescription to ensure it is correct, *there is an additional fee that is not covered by your insurance.* AOA will be happy to coordinate benefits (COB) with your vision insurance ***IF*** COB is allowed by your plan.
- Please be advised that some medical plans cover routine vision services. However, sometimes these vision benefits are with a different carrier. ***AOA may participate with your medical plan but not your vision plan.*** If you are here for a routine vision exam (not a medical exam) and AOA does not participate in your vision plan, you will be responsible for paying in full at the time of service. Please see our financial agreement or visit our website (www.aoaeye.com) for a complete listing.
- **We expect payment at the time of service for all non-covered routine eye care.**

TURN PAGE OVER FOR IMPORTANT REMINDERS ABOUT YOUR APPOINTMENT

Please make sure you are prepared for your appointment!!

- Please allow **2 hours** for a complete eye examination. This will allow enough time for your eyes to dilate and for you to have all necessary tests performed.
- Please **bring your medical insurance cards and photo i.d.** with you to your appointment. Please make us aware of any vision insurance you may have.
- Please **arrive 15 minutes prior** to your appointment time to allow for paperwork. You **may** want to consider coming 30 minutes early to visit our optical shop and pick out a new pair of eyeglasses prior to being dilated.
- Please **bring your current eyeglasses; and if applicable, your contact lens information** for the prescription that you are wearing.
- If you are having a **contact lens examination**, please come in wearing your lenses for at least 2 hours prior to the appointment.
- Please note it may be **necessary to dilate your pupils**. This will result in light sensitivity and blurring of your near vision. This will typically last 3-5 hours. To reduce light sensitivity following dilation, a pair of disposable sunglasses will be given to you if you do not bring your own. We advise our dilate patients to bring a driver or delay driving until dilation is reduced.
- Please be advised that there is **a parking fee** and our office does not validate. You may use Cash or Credit Card to pay your parking, the cost will be no more than $6.00. Please note there is no ATM on site. If you pay with a large bill you will receive dollars, in coin form, back for change.
- **Valet parking** is available for a fee and located in the FRONT of our building.
- If you are unable to keep your scheduled appointment, please give a **24 hour cancellation notice**.

Atlanta Ophthalmology Associates, P.C.

PATIENT INFORMATION

Name: First M.I. Last Nickname

Marital Status: Single/ Married/ Divorced/ Widowed/ Other

Social Security #: _____- _____- _____

Date of Birth: _____/ _____/ _____

Age:

Sex: Male_____ Female_____

Street address:

City:

State:

Zip Code:

Employer:

Occupation:

Who referred you:

Home Phone: ☐ Best Contact for reminders? ( )

Work Phone: ☐ Best Contact for reminders? ( )

Cell Phone: ☐ Best Contact for reminders? ( )

Email Address:

INSURANCE INFORMATION

(Please give your insurance card (s) to the receptionist.)

REFFERAL *MAY* REQUIRED FOR HMO PLANS

Name Primary Insurance:

Policy #:

Group #:

Effective Date:

Policy Holder Name (If NOT yourself):

Policy Holder S.S.N: _____- _____- _____

Date of Birth: _____/ _____/ _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name Secondary Insurance:

Policy #:

Group #:

Effective Date:

Policy Holder Name (If NOT yourself):

Policy Holder S.S.N: _____- _____- _____

Date of Birth: _____/ _____/ _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

VISION INSURANCE

Please be advised that medial insurance is different from vision insurance. If you have separate vision insurance, please fill out the information below. We are vision providers with a select number of vision plans. (Please see back)

Policy #:

Policy Holder Name (If NOT yourself):

Date of Birth: ____/____/____

Social Security #: _____- _____- _____

FINANCIAL INFORMATION

(Person Responsible for Bill if "NOT" yourself)

Name:

Address:

City:

State:

Zip Code:

Relationship:

Phone Number:

IN CASE OF EMERGENCY

Emergency Contact:

Relationship to patient:

Phone Number: ( )

CONTINUE ON BACK

CREDIT POLICY AND FINANCIAL AGREEMENT:

- Please present all insurance cards at check-in and inform check-in if your visit is routine or medical.
- Each patient, ***and not their insurance company***, is responsible for the payment of all charges. Payment is customarily made at the time that services are rendered, unless special arrangements are made in advance. If one of our doctors is a participating physician for your primary insurance plan, payment for any deductibles, co-pay amounts and non-covered services will be **due at the time of service.**
- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non covered Medicare services would be: the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by a supplement insurance plan. **It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full.** Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.
- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services you receive in our office.
  - **Medical Plans that have Vision Benefits:** Please be advised that some medical plans do have routine vision benefits. However, sometimes these vision benefits are with a different carrier. AOA may participate with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether AOA is a provider for both your medical and vision plan. AOA will be happy to coordinate benefits (COB) with your vision insurance ***IF*** COB is allowed by your plan.
  - **Vision Plans:** AOA participates in a very limited number of vision plans. **Drs. Brown and Palay are participating providers for Vision Service Plan ONLY.**

Always Care	Aetna Vision	Anthem Vision	Cigna Vision
EyeMed	MetLife	BlueView Vision	Vision Service Plan

  - **A refraction** (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmic technicians) is typically ***not a covered benefit of your insurance plan***. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge. As a courtesy to you, we will file to your insurance plan and if payment is made, we will be happy to refund your payment.
  - **Contact Lens Exams:** In order to provide you with the contact lenses that give the highest quality of vision, health, and comfort, we require certain additional contact lens related procedures. A comprehensive eye exam does not include any contact lens related services. Prescriptions for contact lenses expire just like medication scripts do. These exams look for vision changes and signs of problems to keep your eyes healthy. **The law requires prescriptions to be updated annually.**

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Atlanta Ophthalmology Associates, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Atlanta Ophthalmology Associates, PC to release any and all information necessary to secure payment.

HIPAA REGULATIONS:

I have READ (and received if requested) a copy of Atlanta Ophthalmology Associates' Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____