Ricardo B. Akstein, MD. F.A.C.S.
General Ophthalmology
Diseases and Surgery of the
Retina and Vitreous

WELCOME

Thank you for choosing Akstein Eye center for your Eye Care and Eyewear needs !
Our staff is eager to assist you in your ophthalmic needs. We realize that in today's busy schedule that time is valuable. Therefore, we have enclosed information that should be completed prior to your arrival on your appointment day to minimize your check-in time at our office.

We are happy to provide you with the best quality Eye Care for you and your family. We have two locations to better serve you. Our main office and Ambulatory Surgery Center are located in Riverdale. Our second office is located in McDonough. Both location offer an Optical Shop to meet your Eyewear needs. Directions to each office can be found on our website at www.aksteineye.com . Alternately you can get driving directions by calling the following numbers:
Riverdale Directions: (770)996-4844 **McDonough Directions: (770)996-4844**

In the future, should you need a prescription refill, you may either request it from our website or by calling our office during normal business hours. If you call between 8:30AM and 5:00PM you will be transferred to one of our technicians. If they are involved with a patient at that time you will need to leave a message in their voicemail box. All calls are returned before the end of the day.

When you come into the office for your appointment please remember to bring the following:

1. Your Current Insurance Card(s)
2. A list of all your current medications
3. Photo I.D.
4. Your most recent glasses
5. **Referral from your Primary Care Physician if required (please check with your insurer)**
6. Any Co-Pays

Should you have any questions or need further assistance please call our office and a member of our staff will be glad to assist you. You may also find that many of your questions are answered on our website at www.aksteineye.com/FAQ

We look forward to meeting you.

Cristina Lopes
Practice Administrator

Akstein Eye Center, P.C.

Patient Information

Today's Date: ___/___/____________ Date of Birth: ____/____/_______
Last Name: ____________________ First Name: ________________ Middle Initial: _________________
Address: ____ State: _________________
City: ____________________ Zip Code: ________________ Social Security#: ____-____-_______
Home Phone: (____)________________ Work Phone: (____)___________ Cell Phone: (____)___________
Gender: M ___ F ___ Ethnicity: ________________ Marital Status: _________________
Email: ____

Guarantor Information (if patient is minor)

Name: _____________________ Date of Birth: _______________ Social Security#: ________________
Address: _______________________________________ Referred By: __________________________________
City: _____________________ State: ______ Zip: __________
Home Phone: (___)_________________ Work Phone: (____)_____________________

Insurance Information

Primary Insurance Coverage Insurance Company: _________________________________
ID Number: _______________ Group Number: _______________ Phone Number: (___)___________
Name of Insured: ____
Insured DOB: ___/___/_______ Insured SSN#: ____-___-_______

Secondary Insurance Coverage Insurance Company: _________________________________
ID Number: _______________ Group Number: _______________ Phone Number: (___)___________
Name of Insured: ____
Insured DOB: ___/___/_______ Insured SSN#: ____-___-_______

Primary Care Physician

Doctor's Name: ____ Phone Number: (___)___________
Address: ____
Referring MD: ____ Phone Number: (___)___________
Address: ____

Emergency Contact Person (Not living with you)

Name: _________________________________
Address: _________________________________
City: __________________________________ State: _______ ZIP: __________
Home Phone: (___)___________ Work Phone: (___)____________ Cell Phone: (___)___________

How Did You Hear About Us?

Doctor Referral? Yes/No ____
Online? Yes/No ____
Social Media? Facebook/Twitter/Google+_________________________ Other: _________
Walk-In? ____

Akstein Eye Center, P.C.

86 Upper Riverdale Road, Riverdale, GA 30274

Patient Health History

Patient Name: ________________________________ **Date:** ________________________

Y N
- □ □ Lung Disease – Type : ____________________
- □ □ Kidney Disease: ______________________
- □ □ Arthritis: ____________________________
- □ □ Diabetes: _____________ # of Years: _______
- □ □ Neurological Disease: __________________
- □ □ Migraines: ____________________________
- □ □ Psychiatric Disorder: ___________________
- □ □ Any Nervous Disorder: __________________
- □ □ Heart Disease: _________________________
- □ □ Gastrointestinal Disease-Type: ___________
- □ □ High blood pressure: ___/___ # of Years: ___
- □ □ Scarring Keloids: ______________________

Your medical doctor: ________________________

Y N
- □ □ Head or Spinal Injuries: ______________________
- □ □ Seizures, Convulsions, or Fainting: ______________
- □ □ Temporal Arteritis: ___________________________
- □ □ Cartoid Artery-Disease: _______________________
- □ □ (Women) Are you pregnant or nursing: _________
- □ □ Stroke: _______________________________________
- □ □ HIV / AIDS: _______________ # of Years: _________
- □ □ Extensive confinement from illness or injury ______
- □ □ Permanent defect from illness, disease or injury
- □ □ Suffering from any other disease: ______________
- □ □ Smoke ? ___Packs ___Per Day ___Week ___Month
- □ □ Alcohol ? # Drinks____Per Day ___Week ___Month
- □ □ Do you live alone ? ____________________________

Please list all medications you are currently taking:

____
____
____
____

Please list all medications you are allergic to:

____
____
____
____

Your Ocular History (Have you been diagnosed with any of the following in the past?)

Y N
- □ □ Cataracts: ___________________________
- □ □ Retinal Disease: _______________________
- □ □ Crossed Eyes: ________________________
- □ □ Iritis: ________________________________

Y N
- □ □ Corneal Disease: ________________________________
- □ □ Glaucoma: _____________________________________
- □ □ Injury: ____
- □ □ Other eye disorders: ____________________________

Cataract Surgery (Date of Surgery) Right Eye: ______________________ Left Eye: __________________________

Do you have a lens implant: Yes □ No □

Other Eye Surgery & Date: Right Eye: ______________________________ Left Eye: __________________________

Explanation of Eye Injury: ____

Family History (Has anyone in your family (blood relative) had any of the following ?

F=Father / M=Mother / P=Paternal / M=Maternal / S=Sister / B=Brother

GF=Grandfather / GM=Grandmother / U=Uncle / A=Aunt

Y N		Relationship
□ □	Glaucoma	________
□ □	Cataracts	________
□ □	Corneal Disease	________
□ □	Macular Degeneration	________
□ □	Retinitis Pigmentosa	________
□ □	Diabetic Retinopathy	________

Y N		Relationship
□ □	Retinal Detachment	_________
□ □	Other eye problems	_________
□ □	Diabetes	_________
□ □	Heart Conditions	_________
□ □	Stroke	_________
□ □	Other General Health Problems	

Surgical History (Please include date and type of surgery- continue on back if needed)

____
____

Akstein Eye Center, P.C.

86 Upper Riverdale Road, Riverdale, GA 30274

Consent for Communications

I understand that as part of my heath care; Akstein Eye Center, P.C. will need to contact me for a variety of reasons including but not limited to: A) appointment reminders, B) clinical instructions, and C) lab results.

My signature below authorizes Akstein Eye Center, P.C. to contact me as follows:

	Number	Voicemail Authorization
Home Phone	____________________	__ YES __ NO
Work Phone	____________________	__ YES __ NO
Cell Phone	____________________	__ YES __ NO
Fax	____________________	__ YES __ NO

I understand that Akstein Eye Center, P.C. does not utilize a secure server for e-mail and as such cannot transmit clinical information via e-mail. I authorize Akstein Eye Center, P.C. to transmit administrative information including but not limited to: A) appointment information and B) billing/insurance information to me via e-mail as listed below.

E-mail Address(es)	Authorized
	__ YES __ NO
	__ YES __ NO

I would prefer that Akstein Eye Center, P.C. contact me in the following manner:

1.
2.
3.

I understand that Akstein Eye Center, P.C. will transmit the minimum amount of information possible when contacting me via these methods. I further understand that I may modify or revoke my authorizations at any time but that such modifications or revocations must be in writing and will not apply to communications prior to the date the authorization was modified or revoked.

Patient Name:__________________________________ **Date Signed:**______________________

Signature of Patient or Guardian: ____

I authorize Akstein Eye Center, P.C. to discuss matters related to my medical care with the following individuals:

____ ____________________________________

Name (Please Print Clearly) Relationship to patient

____ ____________________________________

Name (Please Print Clearly) Relationship to patient

____ ____________________________________

Name (Please Print Clearly) Relationship to patient

Akstein Eye Center, P.C.

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Confirmation of Financial Responsibility

The tests listed below may or may not be covered by your insurance carrier. The benefit information provided to us *is not a guarantee of payment by your insurer:*

Refraction

This is a test that the doctor used to determine the health of your eyes. Your insurance company may not pay for the refraction, even though this is an important part of your exam.

The following list of tests, may or may not be covered by your insurance, but may be necessary to help evaluate and/or treat your eyes:

Visual Field
SLT
Fundus/Optic Disc Photos
Angiogram
Corneal Topography
External Photos
A-Scan
B-Scan
Color VA
Glare Test
Goniscopy
VEP & ERG

I understand and agree that I am responsible for payment of any of the above tests in the event that my insurance company does not cover all or any portion of these tests. I also understand that I am responsible for any co-payments required by my insurance and that I must pay these at the time of service.

____________________________ ____________________
Signature of patient or guardian Date Signed

____________________________ ____________________
Name Printed Employee Initials

Akstein Eye Center, P.C. - Financial Policy and Insurance Agreement

1. I agree to furnish Akstein Eye Center, P.C. with a copy of my current health insurance card(s). I also agree to provide explanation of benefits and/or claims forms wherever applicable.

2. I authorize the release of medical insurance information necessary to process my insurance claim(s) and I assign insurance benefits to Akstein Eye Center, P.C. for services provided to me by Dr. Ricardo B. Akstein.
3. I understand that co-pays are due at the time of service, as required by my insurance company.

4. I agree that I will be responsible for balance not covered by my health insurance plan.

5. In the event that my account is turned over to an outside collection agency, I agree that I will be responsible for any collection fees, court costs, and any other costs associated with the collection effort.

6. I understand that my account will be charged $35.00 when a check I presented for payment is returned marked "Non-sufficient Funds" (NSF). Returned checks over $500.00 will be assess a fee of 5% of the amount of the check.

7. I understand Akstein Eye Center, P.C. will bill my health insurance company and will refund any overpayment on my account to the appropriate party (insurance company or patient).

8. I understand Akstein Eye Center, P.C. allows 30 days for processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim and I will be notified if they do not receive a response.

9. I will notify the Insurance Representative at the practice if I am aware of a payment delay by my insurance company. It is my understanding that the Insurance Representative at the practice will provide me with assistance in resolving the claim.

10. Any co-insurance or deductible amounts will be my responsibility. In the event that I am unable to pay my responsibility in full, I will contact the Insurance Representative to discuss financial arrangement. CO-PAYS are due at the time of service !

11. I understand that any REFERRERALS required by my insurance policy are MY RESPONSIBILITY, and that this must be received prior to the scheduled appointment time. Any PRE-CERTIFICATION for a test or procedure will be the responsibility of Akstein Eye Center, P.C. to obtain prior to performing the service.

I have read, understand and agree to the insurance assignment and financial policies stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with one of the Insurance Specialists employed by Akstein Eye Center, P.C.

____________________________________ ________________________

Signature of Patient or Guardian Date Signed

____________________________________ ________________________

Printed Name Social Security Number

AKSTEIN EYE CENTER

86 Upper Riverdale Road, Riverdale, GA 30274 (770)996-4844

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices how we may use and disclose your protected health information (PHI) to carry out treatment , payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

1. **Uses and Disclosures of Protected Health Information**
   Your protected heath information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services t you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

   Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

   Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

   Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to , quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected heath information to medical school students that see patient at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room where your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

   We may use or disclose your protected health information in the following situation without your authorization. These situation include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

   Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

   You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected heath information.

You have the right to inspect and copy your protected heath information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected heath information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This mean you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Print Name: ____

Signature: ____ Date Signed: __________________