FEES ARE DUE ON DATE OF SERVICE

Patient Information

Prefix: Mr. Mrs. Miss. Ms. Dr.

Last Name _____

First Name _____

Middle _____

Nickname _____

SSN _____

Date of Birth _____

Gender: Male | Female

Race _____

Ethnicity: Non-Hispanic | Hispanic

Address _____

City _____ State ____ Zip _____

Cell Phone _____

Home Phone _____

Work/Other _____

E-mail _____

Single | Married | Widowed | Divorced | Minor

Spouse _____

Phone _____

Do you authorize us to text, email or leave a message on the numbers and email address listed above? Yes | No

Is someone other than the patient responsible for the bill (such as a parent)

☐ Yes ☐ No

If Yes, Name _____

Phone _____

Relationship _____

Address _____

City _____ State ____ Zip _____

Emergency Contacts

Name _____

Relationship _____

Phone Number _____

Employment

Employed | Retired | Student | Homemaker | Unemployed

Employer _____

Occupation/Previous _____

Medical Insurance Information

Please provide your medical insurance card(s) at check in.
We do not file vision insurance.

☐ Self-pay ☐ Medicare ☐ Anthem BCBS
☐ United Healthcare ☐ Aetna
☐ Other _____

Primary Care Physician _____

Signature of patient or caregiver _____ Date _____

REFRACTION SERVICE AND FEE INFORMATION

A refraction is the determination of your best corrected vision. The results from the refraction may be used to prescribe new glasses. The results from the refraction are also necessary to determine whether any medical or surgical treatment may be needed for you. As an example, a refraction is used to gauge whether a cataract may be worsening, necessitating surgery. A refraction is needed to decide if an eye disease is causing your loss of vision. In other words, a refraction is used to assess the overall health of the eyes.

Federal guidelines require that refraction must be billed separately for all patients. Refraction is an essential part of the eye examination, but, unfortunately, it is NOT a covered service by Medicare and many insurance companies.

Our office fee for refraction is $45.00. This fee is collected in addition to any co-payments, co-insurance and unmet deductibles.

PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I,_____ , am authorizing BERG EYE GROUP, PC to release medical information to:

☐ My Emergency Contact (listed on first page)

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Printed Name of Patient_____ Date of Birth_____

I hereby authorize and request the medical treatment necessary for the care of the above patient. I authorize BERG EYE GROUP and/or Meredyth Eye Surgery Center to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.

Signature of patient or caregiver _____ Date _____

Date of Birth _____

Assignment of Benefits & Financial Responsiblity Agreement

Patient Name:_____ Date of Birth:_____

Insurance is filed as a courtesy. It is the patient/guardian responsibility to ensure all bills are paid in full. All co-pays, unmet deductibles and co-insurance are due at the time of services. Self-pay patients must pay charges on the date of services unless other arrangements are made. Surgery patients must pay estimated surgical payments to secure a procedure date.

Medical Testing: Additional testing may be deemed necessary by your provider to diagnose, monitor, and/or treat your medical eye conditions. Charges for these tests are separate from the exam charge and will be submitted to your insurance. Your responsibility for the testing will be based upon your individual benefit plan and the processing of these charges by your insurance. You may be billed for any portion deemed your responsibility or not covered by your insurance company.

Medicare: Claims will be submitted. You are responsible for deductibles, co-insurance, and non-covered services.
Lifetime Signature on File: I authorize Medicare benefits to be paid directly to Berg Eye Group and/or Meredyth Eye Surgery Center.
Medigap: If applicable, I request secondary benefits be sent directly to the provider.

Assignment of Benefits Payment: I authorize my health insurance benefit plan to pay directly to Berg Eye Group and/or Meredyth Eye Surgery Center.

I understand that I am financially responsible for any non-covered charges or outstanding balances. If I am a self-pay patient, I understand that I am responsible for all charges in full at the time of service. I have read and understand the Financial Policy terms and conditions effective 10/1/2026.

I acknowledge that I understand and accept this financial policy.

Signature of Patient or Responsible Party:

_____

Date:_____

PRIVACY NOTICE NOTIFICATION

If you have questions and/or would like additional information regarding the uses and disclosures of health information, you may access our Notice of Privacy Policies (NPP) on our website – www.bergeye.com. You may also obtain a copy by submitting a written request to our Privacy Officer. All requests for Privacy Notice and any report of Privacy Rights Violation must be sent to:

PRIVACY OFFICER
Berg Eye Group
2709 Meredyth Drive, Suite 110
Albany, GA 31707
Fax 229.435.0211

If you believe your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3b70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you know or should have known of the violation. Complaints submitted directly to us must be in writing and the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE HOW TO ACCESS AND RECEIVE A COPY OF OUR PRIVACY NOTICE.

Printed name of patient_____ Date_____

_____ Date _____
Signature of Patient or Patient Representative (if applicable)
Representative's Relationship to Patient (if applicable) _____

To be completed by Berg Eye Group, P.C.
After a good faith attempt to obtain an acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice Notification for the following reason(s)

Signature of Berg Eye Group Representative _____ Date_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES NO Diabetes (Controlled by Insulin, pills, diet)
YES NO Use GLP-1
YES NO Kidney Failure/Dialysis
YES NO Heart Disease, Chest Pain/Angina, Irregular heart rate or Pacemaker
YES NO High Blood Pressure
YES NO Blood Thinners
YES NO Prostate Medicines: Past or Present
YES NO Neurological Disorders _____
YES NO Stomach Ulcer/Hernia/Reflux
YES NO Bleeding Problems
YES NO Drink Alcohol (how much) _____
YES NO Smoke/Tobacco/Vape (how much) _____
YES NO Recreational Drugs _____

YES NO Hepatitis/AIDS/HIV/Tuberculosis
YES NO Arthritis (type) _____
YES NO Thyroid Disease
YES NO Sleep Apnea/Emphysema/Asthma
YES NO Sarcoidosis
YES NO Use of oxygen/CPap to sleep at night
YES NO Claustrophobia/Anxiety
YES NO Problem lying flat
YES NO Wear a hearing aid LT/RT/Both
YES NO Problems with Anesthesia
YES NO Dementia/Alzheimer's
YES NO Cancer (Type) _____

List any surgeries you've had in the past, including eye surgeries:

_____

_____

FAMILY HISTORY:

Has anyone in your immediate family (parents, grandparents, siblings) had problems with any of the following?

YES NO Cataracts YES NO Glaucoma YES NO Macula Degeneration
YES NO Retinal YES NO Diabetes

The information that I've given concerning my medical history is true and correct to the best of my knowledge.

Signature of patient or caregiver _____ Date _____
Date of Birth _____

CURRENT MEDICATION:

☐ I Take NO Medications

List all Medications (prescriptions and non-prescription) that you take. (Including vitamins, herbal remedies, nutritional supplements, over-the-counter, street drugs, etc.) Or if you have a list we can make a copy for our records.

Medication Name	Dose or strength (How many mg, mcg)	How often taken (Once Daily, Twice Daily)

If you require additional space to complete your list of medications, please list the remaining information on the back of this page.

ALLERGIES:

Medication Name & Reaction	Environmental & Reaction	Food & Reaction

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to betadine? ☐ Yes ☐ No

Name of Pharmacy _____ Location _____

Phone _____

Signature of patient or caregiver _____ Date _____

Date of Birth _____