PLEASE PRINT

Center for Sight, P.A.

WELCOME TO OUR OFFICE

R. LEE GRANTHAM, M.D.

PATIENT INFORMATION

1. **NAME** _____ DATE _____
2. **STREET** Address _____ City, State _____ Zip _____
   MAILING Address _____ City, State _____ Zip _____
3. DATE OF BIRTH _____ AGE ____ ❑ MALE ❑ FEMALE SS # _____
4. PLEASE CHECK ONE: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED
5. **HOME** PHONE _____ **WORK** PHONE _____
   CELL PHONE _____ **ALT.** PHONE _____
6. OCCUPATION _____ EMPLOYER _____
   Employer Address _____ City, State _____ Zip _____
7. **SPOUSE** NAME _____ EMPLOYER _____
   Employer Address _____ City, State _____ Zip _____
8. **COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE OR A STUDENT**
   Father's Name _____ Employer _____
   Address _____ Phone _____
   Mother's Name _____ Employer _____
   Address _____ Phone _____
9. NAME OF REFERRING PHYSICIAN OR PATIENT _____
10. ARE YOU RESPONSIBLE FOR THE PAYMENT OF YOUR FEES? ❑ YES ❑ NO ***IF NO, WHO IS?***
    Name _____ Relationship _____ DOB _____
    Mailing Address _____ City, State _____ Zip _____
11. IS ANY PART OF YOUR EYE EXAMINATION COVERED BY INSURANCE? ❑ YES ❑ NO
    DO YOU HAVE ROUTINE VISION COVERAGE? ❑ YES ❑ NO ***If YES, BY WHOM ARE YOU COVERED?***
    ❑ **VISION** INS CO _____ _____ POLICY NUMBER #_____
    ❑ **MEDICARE** NUMBER# _____ **MEDICAID** NUMBER # _____
    ❑ **BC/BS PPO/STATE/FEDERAL** _____ POLICY NUMBER # _____
    ❑ **OTHER MEDICAL INS CO** _____ POLICY / MEMBER # _____ _____
    ❑ **SECONDARY INS CO** _____ POLICY / MEMBER # _____
    ❑ **WORKERS COMPENSATION** (Job Injury) TO WHOM IS BILL TO BE SENT?
12. WHOM TO NOTIFY IN EMERGENCY? *(Nearest Relative)*
    Name _____ Relationship _____
    Street Address _____ City, State _____ Zip _____
    Home Phone _____ Work Phone _____

Financial Responsibility and Authorization to Release Information

I hereby authorize the above doctor/doctors to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Financial Responsibility and Assignment of Insurance Benefits

I understand I am financially responsible to said doctor for all charges. I herby assign to the doctor all money to which I am entitled for expenses relative to all services performed, but not to exceed my indebtedness to said doctor. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full.

Responsible Party's Signature _____ **Patient's Signature** _____ **Date**

MEDICAL HISTORY AND REVIEW OF SYSTEMS

R. Lee Grantham, M.D. Center for Sight, P.A.

NAME _____ DATE _____

DATE OF BIRTH _____ NAME REFERRING PHYSICIAN _____ DATE OF LAST EYE EXAM _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes," provide information.

	YES	NO	PATIENT'S EXPLANATION OF PROBLEM	FOR OFFICE USE ONLY Changes/Date/Initials
Constitutional Symptoms				
Fever	❑	❑		
Weight loss	❑	❑		
Other	❑	❑		
Eyes				
Loss of or Decreased Vision	❑	❑		
Blurred vision (without glasses)	❑	❑		
Distorted vision (Halos)	❑	❑		
Loss of side vision	❑	❑		
Double vision	❑	❑		
Dryness	❑	❑		
Mucous discharge	❑	❑		
Redness	❑	❑		
Sandy or gritty feeling	❑	❑		
Itching	❑	❑		
Burning	❑	❑		
Foreign body sensation	❑	❑		
Excess tearing / watering	❑	❑		
Occasional tearing	❑	❑		
Glare / light sensitivity	❑	❑		
Eye pain or soreness	❑	❑		
Chronic infection of eye or lid	❑	❑		
Sties, Chalazion	❑	❑		
Glaucoma	❑	❑		
Macular degeneration	❑	❑		
Ears, Nose, Mouth, Throat				
Sinus congestion	❑	❑		
Runny nose	❑	❑		
Post-nasal drip	❑	❑		
Chronic cough	❑	❑		
Dry throat / mouth	❑	❑		
Cardiovascular (heart / blood vessels)	❑	❑		
High Cholesterol Medicine	❑	❑		

MEDICAL HISTORY AND REVIEW OF SYSTEMS

R. Lee Grantham, M.D. Center for Sight, P.A.

NAME _____ DATE _____

	YES	NO	PATIENT'S EXPLANATION OF PROBLEM	FOR OFFICE USE ONLY Changes/Date/Initials
High Blood Pressure Medicine	❑	❑		
Respiratory (lungs / breathing)	❑	❑		
Chronic bronchitis	❑	❑		
Asthma	❑	❑		
Gastrointestinal (stomach / intestines)	❑	❑		
Genitourinary (genitals / kidney / bladder)	❑	❑		
Musculoskeletal	❑	❑		
Muscle pain	❑	❑		
Joint pain	❑	❑		
Integumentary (skin and/or breast)	❑	❑		
Neurological (nervous system)	❑	❑		
Endocrine	❑	❑		
Diabetes	❑	❑		
Hematologic / Lymphatic	❑	❑		
Blood	❑	❑		
Lymph nodes	❑	❑		
Swelling	❑	❑		
Allergic / Immunologic	❑	❑		
Head allergy symptoms	❑	❑		
Seasonal allergies	❑	❑		
Hay fever symptoms	❑	❑		
Psychiatric	❑	❑		

PAST HISTORY

List any medications you take _____

_____

List all major illnesses and injuries _____

_____

List any surgeries you have had _____

_____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes, cataract, and/or retinal detachment?

_____

Do you have allergies to any medications? ❑ YES ❑ NO

If YES, list medications? _____

MEDICAL HISTORY AND REVIEW OF HISTORY

R. Lee Grantham, M.D. Center for Sight, P.A.

NAME _____ DATE _____

FAMILY HISTORY

Disease	YES	NO	RELATIONSHIP TO PATIENT *(Self, Mother, Father, etc.)*	FOR OFFICE USE ONLY CHANGES/DATE/INITIALS
Blindness	❑	❑		
Cataract	❑	❑		
Glaucoma	❑	❑		
Macular degeneration	❑	❑		
Retinal detachment	❑	❑		
Arthritis	❑	❑		
Cancer	❑	❑		
Diabetes	❑	❑		
Heart attacks	❑	❑		
Stroke	❑	❑		
High blood pressure	❑	❑		
High Cholesterol	❑	❑		
Kidney disease	❑	❑		
Lupus	❑	❑		
Sjögren's Syndrome	❑	❑		
Thyroid disease	❑	❑		
Tuberculosis	❑	❑		
Other	❑	❑		

SOCIAL HISTORY

Current Occupation _____

Do you drive? ❑ YES ❑ NO

Do you have visual difficulty when driving? ❑ YES ❑ NO

Do you have problems with night vision? ❑ YES ❑ NO

Have you ever tried to wear contacts? ❑ YES ❑ NO

Do you currently wear glasses? ❑ YES ❑ NO

If YES, how long have you had the current pair? _____

Do you drink alcohol? ❑ YES ❑ NO

If YES, how many glasses a day? _____

Do you smoke? ❑ YES ❑ NO

If YES, how many packs a day? _____

Have you ever had a blood transfusion? ❑ YES ❑ NO

History reviewed: ❑ No Changes ❑ Additions as noted above

Physician's Signature: _____ **Date:** _____

Center for Sight, P.A.
139 Waterloo St
Aiken, SC 29801

R. Lee Grantham, M.D.
Ophthalmology

Deb Kohler
Practice Manager

Financial Policy

Please read and sign

In order to reduce any misunderstanding between the Center for Sight, P.A. and our patients, we have adopted the following policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health insurance carrier, full payment is due at the time of service.

Please note that your insurance policy is a contract between you and your health insurance company; the doctor is not involved. If your insurance company does not cover certain diagnoses or procedures, you are responsible for payment.

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans, and you are only required to pay the authorized co-payment at the time of service.

Currently, we file both Primary and Secondary insurances.

If services are rendered to minor patients, then the accompanying parent, adult, or legal guardian is responsible for payment.

If any lab work is ordered; all lab work is done at outside labs, and not included in any of our fees. You will be billed directly by that lab.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also agree that such terms may be amended from time to time by the practice; if changes are made to the policy, I will be asked to resign a document such as this.

Responsible Party's Signature _____ Date

Center for Sight, PA
139 Waterloo St
Aiken, SC 29801

R. Lee Grantham, MD
Ophthalmology

Deb Kohler
Practice Manager

RELEASE OF INFORMATION

In the event that family or friends inquire about your condition, either in person or on the telephone, we would like to know your preference regarding the release of this information. Please read the following options and check the option you desire.

- ❑ I do not wish any information pertaining to me to be released by Center for Sight, PA to family members or caregivers.
- ❑ I agree to allow Center for Sight, PA to release information pertaining to me to family members or caregivers listed below:

_____

_____

_____

_____

_____

_____

_____ _____
Patient or Legal Guardian Signature Relationship to Patient

_____ _____
Witness Date

Refraction Policy

It is Center for Sight P.A.'s policy to do a refraction as a part of an initial, annual, and some post operative eye examinations. Refraction is the process of measuring a patient's refractive error and the clinical judgment to determine the optical correction needed. I am unable to accept another physician or optometrist's refraction as the basis of my clinical judgment. If it is your choice not to have a refraction done, we can refer you to another Ophthalmologist for your eye care.

1. **What is a refraction?** A refraction determines your need for corrective lenses (glasses). However, it can also detect vision loss. Sometimes this loss can be slow, progressive, and go unnoticed by the patient. The test can reveal other conditions that the patient may not detect.

2. **Why doesn't my insurance cover the refraction?** Many health insurance companies including Medicare, consider the refraction to be "vision care" and unrelated to the medical reason for your visit. The separate fee for the service might be covered by your Vision Insurance Plan. You will be provided with a receipt for the refraction which you may choose to file with your Vision Plan. We do not bill for vision services. In the event your Health Insurance Plan does pay for the refraction then you will be reimbursed for that amount.

3. **Do I have to pay for the refraction?** Yes. The Office of the Inspector General has deemed that not charging for a provided service is an "inducement" to the patient and therefore illegal. All services performed must be billed in order to insure that some doctors are not offering incentives to patients for their patronage; which would be unfair to other doctors offering the same service.

Privacy Practices Notification

Center for Sight, P.A.
R. Lee Grantham, M.D.
139 Waterloo St
Aiken, SC 29801

Medical Information

The privacy of your medical information is important. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at Center for Sight, P.A. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights regarding the use and disclosure of your medical information.

The Law

- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information; Keep your medical information private; Follow the terms of the current privacy notice

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law; Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes; Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Medical Information Use and Disclosure

The following describes different ways that we use and disclose your medical information. Not every use or disclosure can be listed. However, we have listed many of the different ways we are permitted to use and disclose medical information.

- **For Reimbursement**
  We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

- **For Your Treatment**
  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

- **Practice Operations**
  We may use and disclose your medical information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to care for you. We may use medical information for purposes of calling you or sending appointment reminders.

- **Information Notification**
  We may use and disclose medical information to notify: a family member, your personal representative or another person responsible about your care. We will share information about your general condition. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies or medical information for you.

- **Government Activities, Court Orders, Judicial and Administrative Proceedings:**
  Subject to certain requirements, we may disclose or use your health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
  We may disclose medical information in response to a court order, subpoena, discovery request, or other lawful process, under certain circumstances. We may share limited information with a law enforcement official concerning the medical information of a suspect fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

- **Victims of Abuse, Neglect, or Domestic Violence:**
  We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, child abuse or neglect, or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of others.

- **Public Health Activities:**
  As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects, to enable product recalls, and to track products.

- **Workers Compensation:**
  We may disclose health information when authorized or necessary to comply with workers compensation laws.

You Have the Right to:

- Look at or get copies of certain parts of your medical information. You must make your request in writing. There may be charges for copying and for postage if you want the copies mailed to you.
- Request in writing that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by this agreement (except in the case of an emergency). You may request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed.
- If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request.

Questions and Concerns:

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. You may also submit a written complaint to the U.S. Department of Health and Human Services; we will not retaliate in any way if you choose to file a complaint.

_____ _____

Signature Date

MEDICATIONS LIST

R. LEE GRANTHAM, M.D. **CENTER FOR SIGHT, P.A.**

PATIENT NAME: _____ **DATE OF BIRTH:_____**

MO	DAY	YR	MEDICATIONS	DOSAGE	FREQUENCY	ROUTE ORAL, INJECTED	STAFF INITIALS