Georgia Eye ASSOCIATES

Donald E. Poland, M.D.
General Ophthalmology
Corneal and External Disease
Refractive Surgery

Kris F. Gillian, M.D.
General Ophthalmology
Refractive Surgery

Dickie McMullan, M.D.
General Ophthalmology
Corneal and External Disease
Refractive Surgery

Frank L. Winski, O.D.
Optometry

Brian A. Kahn, O.D.
Optometry

Brigette Rabitsch, O.D.
Optometry

Dear Patient,

Thank you for choosing Georgia Eye Associates. We strive to provide you with state of the art eye care in comfortable surroundings.

Attached are maps and directions to our three offices. Please note the location of your appointment and follow the corresponding directions. If you need further assistance do not hesitate to give us a call.

Please complete the enclosed forms and bring them with you when you come in for your appointment. Your medical history is very important to us.

A complete eye exam includes dilation. Dilation involves widening the pupils using eye drops. The effects can last several hours. It may cause light sensitivity and blurred near vision, but most people have no trouble driving after the exam. If you are concerned about driving after dilation, please bring someone to drive you.

If you wear contacts, please call our office to inquire about our contact lens policies and prices. We cannot release contact lens prescriptions to new patients until we have fit your eyes.

If you must change or cancel you appointment, please try and give at least 24 hours notice. Your consideration is greatly appreciated.

Sincerely,

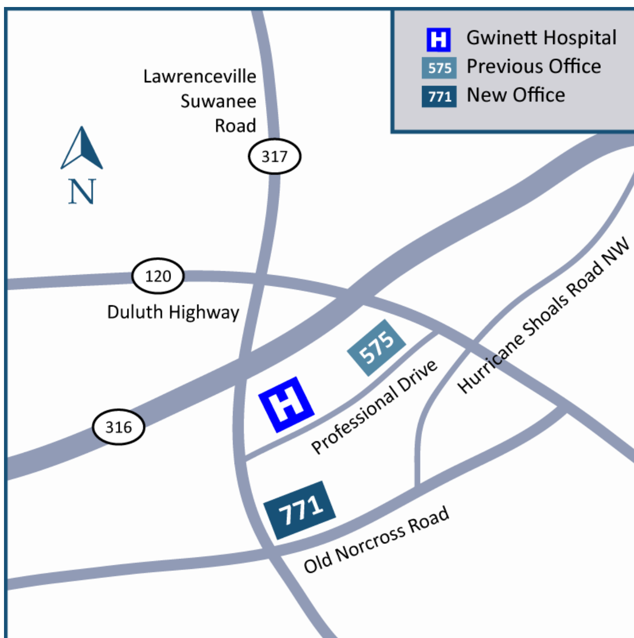
Donald E. Poland, M.D.
Kris F. Gillian, M.D.
Dickie McMullan, M.D.
Frank L. Winski, O.D.
Brian A. Kahn, O.D.
Brigette Rabitsch, O.D.

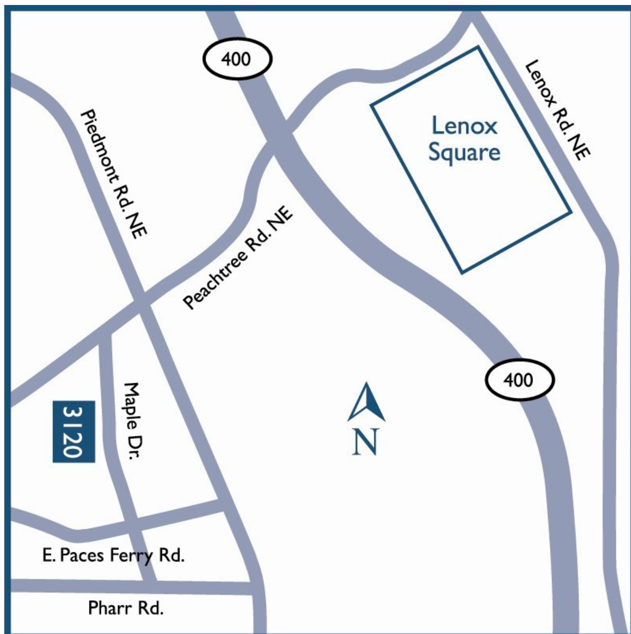
Lawrenceville
771 Old Norcross Road
Suite 150
Lawrenceville, GA 30045
770-995-5408
Fax: 770-513-2042

Atlanta
3120 Maple Drive
Atlanta, GA 30305
404-233-3267
Fax: 404-233-4399

Tucker
2368 Main Street
Suite B
Tucker, GA 30084
770-938-0020
Fax: 770-939-1256

www.GeorgiaEyeAssociates.com





Lawrenceville Office
771 Old Norcross Rd., Terrace Park Medical Building
Suite 150, Lawrenceville, GA 30045,
Phone: **770-995-5408**, Fax: **770-513-2042**

From the North (Buford, Braselton):
Take I 85 South to Exit 111 (Suwanee). Turn left onto GA-317/Lawrenceville Suwanee Rd and go east. Travel six miles to the Old Norcross Rd. intersection. Georgia Eye Associates is on the left at the intersection (blue building).

From the South (Downtown, Midtown, Buckhead):
Take I 85 North to Route 316. Travel approximately three miles and exit route 120/Duluth Highway. Turn left onto 120/Duluth Highway. Travel 0.5 miles to Lawrenceville Suwanee Rd. Turn left onto Lawrenceville Suwanee Rd. Travel one mile. Georgia Eye Associates is on the left at the Old Norcross Rd. intersection (blue building).

From the East:
Take 316 westbound and exit 120 East (Duluth Highway). Turn right at 120/Duluth Highway. Travel 0.5 miles to Lawrenceville Suwanee Rd. Turn left onto Lawrenceville Suwanee Rd. Travel one mile. Georgia Eye Associates is on the left at Old Norcross Rd. intersection (blue building).

Buckhead Office
3120 Maple Dr., Atlanta, GA 30305
Phone: **404-233-3267,** Fax: **404-233-4399**

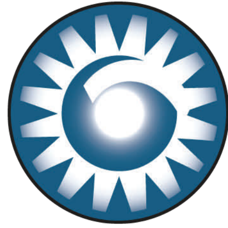
From the North (Gainesville, Lawrenceville, Duluth):
Take I 85 South to exit 88 – Cheshire Bridge/Lenox Rd/GA-400.
Turn right onto Lenox Rd and drive about 2.5 miles.
Turn left onto Peachtree Rd., NE
Crossover Piedmont Rd.
Take a left onto Maple Dr.
Georgia Eye Associates is on the right.

From the South (Airport,Downtown, Midtown):
Take I 85 North and merge onto GA-13 N via Exit 86.
Take the GA-237 N/Piedmont Rd. ramp.
Turn right onto Piedmont Rd. NE/GA-237.
Turn left onto East Paces Ferry Road NE.
Turn right onto Maple Dr.
Georgia Eye Associates is on the left.

Tucker Office
2368 Main St., Suite 2., Tucker, GA 30084
Phone: **770-938-0020,** Fax: **770-939-1256**

From the North (Gainesville, Lawrenceville, Duluth):
Take I 85 South to Exit 96 (Pleasantdale Rd). Turn left.
Continue along Pleasantdale Rd. It will turn into Chamblee Tucker Rd. Turn left onto LaVista Rd. (Tucker High School will be on the left.)
At the first traffic light, turn right onto Main St.
Georgia Eye Associates is the 5th building on the right.

From the South (Airport, Downtown, Midtown):
Take I 85 North to I 285 East to Exit 37
Turn left onto LaVista Rd. Travel about 2 miles.
Turn right onto Main St. (Tucker High School will be on the left)
Georgia Eye Associates is the 5th building on the right.



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OFFICE POLICY ON MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered, and even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality eye care for our patients is our primary concern. We are more than willing to provide that care within your insurance contracts guidelines if you let us know at the time of each service what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently perform services such as photos, visual field or procedures that are not covered; we will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

In event that services are provided and your coverage is not in effect on that day then fees submitted and denied by your carrier will become your responsibility.

With your cooperation and help, you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your eye needs.

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NEW PATIENT HISTORY RECORD

Name: ____ **Date:** ________________

PAST EYE HISTORY (List any previously diagnosed eye illness or operation)

____

CURRENT EYE MEDICATIONS (List all eye drops or ointments)

____

PAST MEDICAL HISTORY

	YES	NO		YES	NO
TUBERCULOSIS	____	___	HIGH BLOOD PRESSURE	____	___
CANCER	____	___	KIDNEY DISEASE	____	___
DIABETES	____	___	THYROID DISEASE	____	___
BLOOD DISORDERS	____	___	LUNG DISEASE	____	___
HEART DISEASE	____	___	NEUROLOGIC DISORDERS	____	___

OTHER (DESCRIBE) ____

MAJOR SURGERIES (DESCRIBE) ____

MEDICATIONS (List all oral medications which you take on a regular basis)

____
____
____
____

ALLERGIES (List all drugs or substances to which you are allergic)

____

FAMILY HISTORY

DO ANY MAJOR ILLNESSES OR EYE DISEASES RUN IN YOUR FAMILY? ( ) YES ( ) NO IF YES, EXPLAIN:____________

____

SOCIAL HISTORY

DO YOU SMOKE?	( ) YES	( ) NO	IF YES, HOW MUCH? ______________________
DO YOU DRINK ALCOHOL?	( ) YES	( ) NO	IF YES, HOW MUCH?______________________
HAVE YOU EVER USED DRUGS?	( ) YES	( ) NO	IF YES, EXPLAIN: ________________________
HAVE YOU EVER HAD A BLOOD TRANSFUSION?	( ) YES	( ) NO	

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS: **IF YES, please explain:**

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE	( ) YES	( ) NO ___________________
EAR/NOSE/THROAT PROBLEMS (e.g., hearing loss sinus problems, sore throat)	( ) YES	( ) NO___________________
HEART PROBLEMS (e.g., chest pain, irregular heart beat)	( ) YES	( ) NO___________________
RESPIRATORY PROBLEMS (e.g., shortness of breath, wheezing, coughing)	( ) YES	( ) NO___________________
GASTROINTESTINAL PROBLEMS (e.g., heartburn, abdominal pain, diarrhea, vomiting)	( ) YES	( ) NO___________________
URINARY PROBLEMS (e.g., pain or discomfort, blood in urine)	( ) YES	( ) NO___________________
SKIN PROBLEMS (e.g., rashes, excessive dryness)	( ) YES	( ) NO___________________
MUSCULOSKELETAL PROBLEMS (e.g., muscle aches, joint pain, swollen joints)	( ) YES	( ) NO___________________
NEUROLOGIC PROBLEMS (e.g., numbness, weakness, headaches, paralysis)	( ) YES	( ) NO___________________
PSYCHIATRIC PROBLEMS (e.g., depression, anxiety)	( ) YES	( ) NO___________________
ALLERGIC PROBLEMS (e.g., hay-fever, sinus problems, runny nose)	( ) YES	( ) NO___________________

ARE YOU INTERESTED IN LEARNING MORE ABOUT LASIK LASER VISION CORRECTION?

( ) YES ( ) NO

History Reviewed. ( ) No changes ( ) Changes as noted Physician:_____________________________ Date:______________

PATIENT INFORMATION

Date: __________________________

PATIENT NAME: ____
(LAST) (FIRST) (MI)

ADDRESS: ____
(STREET (P.O.BOX) (APT #)

____
(CITY) (STATE) (ZIP CODE)

HOME PHONE: ________________________ SOCIAL SECURITY NO: __________________________

PATIENT EMPLOYED BY: ____

OCCUPATION: __________________________ BUSINESS PHONE: _____________________________

PATIENT SEX: ( ) MALE ( ) FEMALE CELL PHONE:____________________________

AGE:________________________________ MARITAL STATUS: _____________________

DATE OF BIRTH: ______________________ EMAIL ADDRESS:________________________________

PERSON TO NOTIFY IN AN EMERGENCY: ___________________________ PHONE:_______________

INSURANCE POLICY HOLDERS INFORMATION

(Complete only if someone other that the patient is insurance policy holder)

NAME: _____________________________________RELATION TO PATIENT: ___________________________

ADDRESS: ____ CITY, STATE, ZIP: _____________________________

HOME PHONE: ___________________________ SOCIAL SECURITY NO: ___________________

DATE OF BIRTH: _____________________________ SEX: ( ) MALE ( ) FEMALE

EMPLOYER ADDRESS: _______________________________________BUSINESS PHONE:______________________

INSURANCE INFORMATION (Complete only if you have made prior arrangements with Receptionist to file insurance)

NAME OF PRIMARY INSURANCE COMPANY:____
NAME OF SECONDARY INSURANCE COMPANY:____

PLEASE NOTE: WE FILE INSURANCE AS A COURTESY FOR OUR PATIENTS. WE DEAL WITH OVER 700 INSURANCE CARRIERS AND IT IS IMPOSSIBLE FOR US TO KNOW THE SPECIFIC DETAILS ON HOW EACH INSURANCE WORKS. IT IS YOUR RESPONSIBILITY TO KNOW THE SPECIFICS OF YOUR PLAN. WE SUGGEST YOU CALL YOUR INSURANCE CARRIER BEFORE YOUR VISIT TO SEE IF 1) THE PROVIDER YOU ARE SEEING IS A COVERED PROVIDER, 2) DO YOU HAVE A DEDUCTIBLE TO MEET BEFORE YOUR INSURANCE PAYS. 3) DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSCIAN BEFORE BEING SEEN AND 4) IF THE PURPOSE OF YOUR VISIT IS A ROUTINE EYE EXAM THEN MAKE SURE YOU HAVE ROUTINE VISION COVERAGE.

ASSIGNMENT AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSCIAN AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES OR UNPAID BALANCE, AND ANY LEGAL FEES NECESSARY TO COLLECT THE UNPAID BALANCE. I ALSO AUTHORIZE MY PHYSCIAN TO RELEASE ANY INFORMATION REQUIRED IN PROCESSING OF THESE BENEFITS.

PATIENTS'S SIGNATURE:____ DATE_______________________________

(rev 2-05)

METHOD OF PAYMENT: ( ) CASH ( ) CHECK ( ) CREDIT CARD ( ) OTHER ________________

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ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Georgia Eye Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Georgia Eye Associate's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Georgia Eye Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Georgia Eye Associates Privacy Officer at 771 Old Norcross Road, Suite 150, Lawrenceville, GA 30045.

With this consent, Georgia Eye Associates 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 appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Georgia Eye Associates 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 as long as they are marked Personal and Confidential.

With this consent, Georgia Eye Associates may e-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. I have the right to request that Georgia Eye Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

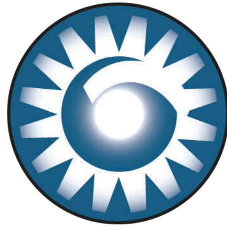
By signing this form, I am consenting to Georgia Eye Associate's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Georgia Eye Associates may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian



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ASSOCIATES

Whom May We Thank for Referring You?

Please Circle Office Location: ● Lawrenceville ● Buckhead ● Tucker

Your Name____

E-mail Address____

☐ Check if we may add your name to our e-mail list to receive discounts and updates from Georgia Eye Associates

Referral Information: Please check all that apply

- ☐ Family/Friend Name:_______________________________
- ☐ Doctor Name:___________________________________
- ☐ Optometrist Name:_______________________________
- ☐ Price & Wood Opticians
- ☐ Insurance Referral:_______________________________
- ☐ Georgia Eye Associates Website
- ☐ Internet Referral ☐Google ☐Yahoo ☐Other
- ☐ Yellow Pages BOOK (hard copy)
- ☐ Yellow Pages. **COM** (on-line)
- ☐ Advertisement/Billboard
- ☐ Postcard
- ☐ Other (Please explain):_______________________________

www.GeorgiaEyeAssociates.com