Schulze EYE & SURGERY CENTER

Patient Information

Date: _____ **Referred By:** _____

Patient's Name: _____ Male: ☐ Female: ☐

Address: _____

City: _____ State: _____ County: _____ Zip: _____

Phone: Home: (___)-_____ Work: (___)-_____ Cell: (___)-_____

E-mail: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Employer: _____

Address: _____

City: _____ State: _____ County: _____ Zip: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: (___)-_____

City: _____ State: _____ County: _____ Zip: _____

Eye and Medical Care Provider Information:

Current Optometrist or Ophthalmologist: _____ Date of Last Visit: _____

Address: _____ Phone: (___)-_____

Primary Care Physician/MD: _____ Phone: (___)-_____

Insurance Information:

Medicare Number: _____ Medicaid Number: _____

Name of Insurance Company (Primary): _____

Name of Policy Holder (if other than yourself): _____

Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Insurance Company Claims Address: _____

Name of Insurance Company (Secondary): _____

Name of Policy Holder (if other than yourself): _____

Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Insurance Company Claims Address: _____

d

Schulze EYE & SURGERY CENTER

Financial Policy

Insurance:
Schulze Eye Center, PC and Schulze Surgery Center Inc. participates in traditional Medicare and many commercial insurance plans and cannot know the details of the coverage and benefits for your particular policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. Your insurance may have one or more of the following requirements:

- Referral from your primary care physician ("PCP") authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, it usually means that physician must authorize your care by a specialist.) Note that if you were referred to us by another eye care professional, that may not meet your insurance plan's requirement for a referral authorization from your PCP. If your insurance policy requires this referral, **it is your responsibility to make sure we have authorization prior to you being seen by our doctor. Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled.** While this may seem harsh it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatment that result from an unauthorized initial visit. Note that if you have a secondary insurance company or are covered by a Medicare Advantage Plan through a commercial insurer which replaces traditional Medicare Part B coverage, please consider whether that insurance company may require prior referral authorization. If they do, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf. If you are unsure of what you need, call the number on your insurance card or your PCP before your visit.
- Co-pay that must be paid each visit
- Annual deductibles that apply. Note a separate deductible may apply for out-of-network services.
- Specific facilities that must be utilized from hospitalization, diagnostic, or surgical services to obtain the most favorable reimbursement. An HMO may not have any out-of-network benefits. Please note that surgical services we offer will be provided in Schulze Surgery Center. Schulze Surgery Center is contracted with many insurance plans, but you will need to check with your insurance company to determine if it is in-network or not.

Patient responsibility balances. You will be responsible for:

- Co-pays (will be collected at check-in) and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage of the allowed amount that is your obligation).
- Self-Pay, Services not covered by insurance, and large deductibles. If you do not have medical insurance, your insurance does not cover some or all our services, or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service. Similarly, if you require surgery, require prepayment towards the cost of surgical procedures. We are familiar with the payable diagnoses for our highly specialized office testing. You may be informed your insurance will not pay for a diagnostic test our physician feels is necessary to formulate your treatment plan. Should you wish to proceed with this particular diagnostic procedure, you will be given the cost and asked to sign a Waiver acknowledging you understand you are responsible for paying the cost of the test the day of the visit.
- If after speaking with your insurance company you have unanswered financial questions, our staff and billing department will be happy to help you plan to meet the costs of your care. Please call our office at (192) 352-3120 or our billing department at (844) 878-8053. Note that we are able only to give rough estimates of costs for any surgical services prior to your procedure.

Payment methods. For your convenience, in addition to cash or personal check, we also accept VISA, MasterCard, Discover, and American Express cards. Please be aware that checks returned for insufficient funds will result in a fee being added to your account; if returned a second time it may be referred to for collection.

Acknowledgment and Authorization. I have read, understand, and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for a professional service rendered. I authorize the release of medical information necessary to process claim for benefits under my policy and assign payment of my insurance benefits to Schulze Eye Center, PC and/or Schulze Surgery Center Inc. If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

Patient's Signature: _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____

Facility Representative's Signature: _____ **Date:** _____

Schulze EYE & SURGERY CENTER

HIPAA Consent

Authorization for Use and Disclosure of Protected Health Information (PHI)

This form authorizes **Schulze Eye and Surgery Center** to use and disclose your Protected Health Information (PHI) in accordance with federal (HIPAA) and Georgia state law, including the use of telehealth and electronic communications.

Purpose of Disclosure

I authorize the use or disclosure of my PHI for the following purposes:

Treatment: Coordination of care, including telehealth visits and consultations between healthcare providers.
Payment: Billing and payment processes, including insurance claims.
Healthcare Operations: Quality assessments, audits, and administrative purposes.

Specially Protected Information

Certain types of information require additional consent under Georgia law:

HIV/AIDS Status **Mental Health Records** **Substance Use Disorder Treatment** **Genetic Information**

☐ **I authorize** the release of the above information as needed for my care.
☐ **I do not authorize** the release of the above information.

Expiration and Revocation

This authorization will remain in effect until:
☐ **A specific date:** _____ ☐ **Until I revoke it in writing.**

I understand that I may revoke this authorization at any time by providing written notice to Schulze Eye and Surgery Center. Revocation will not affect any disclosures made prior to receiving the notice.

7. Patient Rights and Acknowledgment

I understand that:

I have the right to refuse to sign this authorization.

I have the right to request restrictions on how my PHI is used or disclosed.

Refusal to sign may impact the ability of Schulze Eye and Surgery Center to provide treatment or bill my insurance.

Patient Name Printed:_____ **Date:**_____

Patient Signature:_____

Guardian/Representative (if applicable):_____

Relationship to Patient:_____

Clinic Representative:_____ **Date:**_____

Notice of Privacy Practices and Patient Bill of Rights Acknowledgement

I acknowledge that I have received, reviewed, and understand the Notice of Privacy Practices and Patient Bill of Rights. I may request at anytime a paper copy of these forms or I can access them at www.schulze-eye.com under the “Forms” tab.

Patient Name Printed:_____ **Date:**_____

Patient Signature:_____

Schulze EYE & SURGERY CENTER

Patient Communication Form

Preferred Methods of Communication

Please indicate how you prefer to be contacted regarding your medical care, appointments, and other communications:

- **Appointment Reminders (check all that apply):**
  ☐ Phone Call ☐ Text Message ☐ Email
- **Billing and Insurance Information (check all that apply):**
  ☐ Phone Call ☐ Text Message ☐ Email
- **Medical Information and Test Results (check all that apply):**
  ☐ Phone Call ☐ Text Message ☐ Email ☐ Patient Portal
- **Other Communications (check all that apply):**
  ☐ Phone Call ☐ Text Message ☐ Email

Consent for Electronic Communication

By signing below, I consent to receive electronic communications from Schulze Eye & Surgery Center. I understand that electronic communications, including text messages and emails, may not be secure and could be accessed by unauthorized individuals. I accept the risks associated with this form of communication and release Schulze Eye & Surgery Center from liability related to unauthorized access.

I also understand that I may withdraw my consent at any time by notifying the office in writing.

Signature: _____
Date: _____

Alternate Contact Authorization

I authorize Schulze Eye & Surgery Center to communicate with the following person(s) regarding my appointments, billing, or medical care:

- **Name:** _____
  Relationship: _____
  Phone Number: _____

☐ I do not authorize any additional contacts.

Acknowledgment and Consent

I acknowledge that I have read and understand the above communication preferences and have selected my preferred methods of contact.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (if applicable): _____ **Date:** _____

Consent for Treatment and Refraction Policy

Consent for Treatment:

I authorize Schulze Eye Center, PC and/or Schulze Surgery Center, Inc. to assess and treat men, complete tests, and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.

I understand that my pupils may be dilated as part of the appointment. For some, dilation and other drops used during the visit may cause light sensitivity and blurry vision for a period of time.

Patient's Signature: _____**Date:** _____

Disclosure:

Please be advised that Dr. Richard R. Schulze Jr. owns Schulze Eye Center, PC and Schulze Surgery Center, Inc. You are entitled to obtain services for which you have been referred from the location of your choice.

I acknowledge the disclosure of the information set forth regarding Schulze Eye and Surgery Center.

Refractive Policy:

I hereby acknowledge and understand that during the course of my treatment certain procedures may need to be performed that **most insurance companies, including Medicare, to not cover.**

Why is refraction necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or visual complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction is necessary to see if this is due to a need for corrective lenses or due to a medical problem.

Our office policy is to charge $69.00 for this procedure in addition to the office visit. This is due at the time services are rendered, unless covered by your insurance.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. Co-pays and deductibles are separate from, and not included in, the refraction fee.

Patient's Signature: _____**Date:** _____

Printed Name: _____

Note: Refractions are listed under exclusions, with Medicare benefit policy 100.02, Section 90:

"Routine physical checkups: eyeglasses, contact lenses and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, eye refractions by whatever practitioner and for whatever purpose performed."

You may find additional information online at cms.hhs.gov/manuals

Schulze
EYE & SURGERY CENTER

Elective Retinal Photography Consent

As part of your comprehensive eye exam, Dr. Schulze recommends that you have digital photographs of the back portion of your eye (retina). This advanced technology produces detailed images of not only the retina, but also its blood supply and the optic nerve which connects your eyes to the brain. These photos become a permanent record of your eye health, establish a baseline for comparison in future years, and enable the Doctor to help detect subtle changes earlier and diagnose possible disease sooner. In some cases, these images can detect diabetic eye changes, macular degeneration, high blood pressure, and glaucoma.

Screening digital retinal photography is not covered by most medical insurance plans. **There is a $50 fee (includes both eyes) for the procedure.** We always hope that these screening photos do not identify any medical health concerns, but if Dr. Schulze does identify any issues, we may be able to bill the photos to your medical insurance. **While taking these images does not replace the need to have your eyes dilated, it is strongly recommended you have images taken.** This ensures that Dr. Schulze is able to get a reasonable view of the eye and your retinal health.

☐ **Yes**, I want to have the retinal photos for my record, and I understand there will be a $50 fee if my medical insurance cannot be billed or does not cover this procedure.

☐ **No**, I Do **NOT** consent to retinal photos. I understand that there will not be a photographic record of my current internal eye health.

Patient's Signature: _____ **Date:** _____

Printed Name: _____

Schulze EYE & SURGERY CENTER

Patient Medical History

Name: _____ **Height:** _____ **Weight:** _____ **Date:** _____

Allergies: (please include type of reaction) ☐ **None** ☐ Latex Allergy

Allergy:	Reaction:	Severity:
Allergy:	Reaction:	Severity:
Allergy:	Reaction:	Severity:

Pharmacy Name: _____ **Pharmacy Location:** _____

Medication List: ☐ **None**

(list names, dosages and frequency of all medications including over the counter and herbal supplements)

Past Ocular History: (please check all that apply) ☐ **None**

☐ Amblyopia	☐ Diabetic Retinopathy	☐ Near sighted	☐ Optic Neuritis
☐ Aphakia	☐ Dry Eyes	☐ Iritis	☐ Retinal Detachment
☐ Astigmatism	☐ Glaucoma	☐ Keratoconus	☐ Eye Injury
☐ Cataracts	☐ Far sighted	☐ Macular Degeneration	Other:

Do you wear: ☐ Glasses ☐ Contacts: ☐ Hard ☐ Soft How many years?_____

Past Ocular Surgeries: (please check all that apply) ☐ **None**

☐ Cataract Surgery	☐ RK	☐ Punctal Plugs	☐ PI
☐ Corneal Transplant	☐ Blepharoplasty	☐ Strabismus Surgery	☐ Ocular Injections
☐ LASIK	☐ Foreign Body Removal	☐ Glaucoma Surgery	Other:
☐ PRK	☐ Retinal Laser Surgery	☐ Vitrectomy	Other:

Past Medical History: (please check all that apply) ☐ **None**

☐ Anemia	☐ COPD	☐ High Cholesterol	☐ Liver Disease
☐ Arthitis	☐ Diabetes	☐ HIV	☐ Herpes Zoster
☐ Arrhythmia	☐ Eczema	☐ Lung Disease	☐ Psychiatric Disorder
☐ Asthma	☐ Fibromyalgia	☐ Lupus	☐ Stroke
☐ Bleeding Disorder	☐ Headache	☐ Migraine	☐ Multiple Sclerosis
☐ Cancer	☐ Hearing Loss	☐ Polymyalgia	☐ Sjogren's
☐ Thyroid Disease	☐ Hepatitis	☐ Grave's Disease	Other:
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Kidney Disease	Other:

Past Surgical History: (please list surgeries you have had) ☐ **None**

Schulze EYE & SURGERY CENTER

Patient Medical History

Name: _____ **Date:** _____

Family History: (please check all that apply) ☐ **None** ☐ Unknown

	Relationship		**Relationship**
☐ Blindness		☐ High Blood Pressure	
☐ Cancer		☐ Macular Degeneration	
☐ Diabetes		☐ Retinal Disease	
☐ Glaucoma		☐ Stroke	
☐ Heart Disease			

Social History: Do you use? (please check all that apply) ☐ **None**

Tobacco Products	☐ Yes	☐ No	☐ Former	☐ Never
Alcohol	☐ Yes	☐ No	How much	How often?
Recreational Drugs	☐ Yes	☐ No	What?	How often?

Visual Function:

Decreasing vision can cause changes in your daily life. To help us evaluate your level of visual function it is important to know the problems you are having as you go through your daily activities. Do you have problems, even with glasses with: (please check all that apply)

☐ Reading traffic signs, street signs, or store signs?	☐ Playing sports like golf or bowling?	☐ Seeing well in poor light?
☐ Reading newspaper, books, or magazines?	☐ Watching TV?	☐ Seeing rings or haloes around lights?
☐ Reading fine print, medicine bottle labels, or phone books?	☐ Recognizing people's faces?	☐ Trouble driving at night?
☐ Driving during the daytime?	☐ Doing fine hand work like knitting, sewing or carpentry?	☐ GLARE with performing normal daily activities?
☐ Seeing steps or curbs?	☐ Trouble with hobbies or crafts?	☐ GLARE when driving toward headlights or in bright sunlight?
☐ Writing checks or filling out forms?	☐ Cooking, cleaning, or yard work?	☐ GLARE when walking outside on a sunny day?
☐ Playing card games or bingo?	☐ Hazy or blurry vision?	☐ GLARE from TV or a computer screen?

Surgery can almost always be safely postponed until you feel you need better vision; however, if you feel at all hampered by the best vision that glasses can provide, then surgery becomes a reasonable option. If stronger glasses will not improve your vision anymore and if the only way to help you see better is surgery, do you feel your vision problem is bad enough to consider surgery now? ☐ **Yes** ☐ **No**

Surgery to reduce or eliminate your dependence upon glasses for distance, mid-range, and near vision is available but is not covered by insurance. Would you be interested in learning more about this option?

☐ **Yes** ☐ **No**

Schulze EYE & SURGERY CENTER

Notice of Privacy Practices

Your Rights Under HIPAA (Health Insurance Portability and Accountability Act) This Notice describes how your medical information may be used, disclosed, and how you can access your information. This notice also outlines your rights under federal law (HIPAA) and includes additional protections provided by Georgia states law. Please review it carefully. Effective 02/11/2025

1. Your Rights You have the following rights regarding your health information:

Access Your Records: You can request to see or get a copy of your medical records.
Request Corrections: You may ask us to correct your records if you believe they are incomplete or inaccurate.
Confidential Communications: You can request that we contact you in a specific way (e.g., phone or email) or send mail to a different address.
Limit Use & Disclosure: You may request restrictions on how we use or disclose your information, although we may not be able to fulfill all requests.
Request an Accounting of Disclosures: You can ask for a list of certain disclosures of your health information.
Receive a Copy of This Notice: A paper or electronic copy of this notice is available upon request.

2. How We May Use and Disclose Your Health Information We may use and share your health information for the following purposes:

Treatment: Sharing your information with healthcare providers involved in your care.
Payment: Using your information to bill and collect payment for services provided.
Healthcare Operations: Using your information for business operations, including quality assessment and improvement activities.
Legal Requirements: Disclosing your information when required by law, including public health and safety issues.
Law Enforcement: Sharing your information in response to court orders, subpoenas, or law enforcement requests.
Research: Using your information for research purposes with your consent or as allowed by law.
Marketing & Fundraising: Using your information for marketing or fundraising purposes only with your explicit authorization.

3. Your Choices In certain situations, you have additional choices about how we use and share your information:

Marketing & Sale of Information: We will only share your information for marketing or sell your information with your written permission.
Psychotherapy Notes: Use and disclosure of psychotherapy notes require your authorization.

4. Our Responsibilities We are required to:

Maintain the privacy and security of your health information.
Provide you with this notice of our legal duties and privacy practices.
Notify you in the event of a breach that may compromise the privacy or security of your information.
Follow the duties and privacy practices described in this notice and offer you a copy of it.

1. Additional Privacy Protections Under Georgia Law Georgia law provides specific privacy protections beyond federal requirements:

HIV/AIDS Information:
Information regarding HIV/AIDS status is considered highly confidential and can only be disclosed with your explicit written consent, except when required by law (e.g., to public health authorities).

Mental Health Records:
Mental health records are protected under Georgia law and require your consent for disclosure unless they are needed for emergency treatment, court orders, or other legally authorized reasons.

Substance Use Disorder Records:
Information related to substance use disorder treatment is protected under both federal and state law, requiring specific written consent for disclosure.
Genetic Information:
Under Georgia law, genetic information cannot be disclosed to third parties (such as insurers or employers) without your explicit consent, except in limited situations allowed by law.

Minors' Rights:
Minors in Georgia may consent to certain treatments (e.g., for sexually transmitted infections, pregnancy, and mental health services) without parental consent. In such cases, the minor's privacy is protected, and parents may not have access to these records without the minor's permission.

2. How We May Use and Disclose Your Information Under Georgia Law In addition to the federal guidelines outlined in this notice, Georgia law permits or restricts the use of your health information as follows:

Public Health Reporting:
We may disclose information for public health activities, including reporting communicable diseases, but only as required by Georgia law.
Court Orders and Legal Proceedings:
Your health information may be disclosed in response to a court order, but we will make every effort to protect your privacy and inform you of the disclosure if possible.
Law Enforcement Disclosures:
Disclosure to law enforcement is limited to specific situations allowed by Georgia law, such as reporting certain injuries or complying with legal processes.

3. Breach Notification

Georgia law requires that you be notified if your personal information, including health information, is compromised in a security breach. This notification will include details of the breach and steps you can take to protect yourself.

4. Filing Complaints Under Georgia Law

If you believe your privacy rights have been violated, you can file a complaint with:

Kate Lyker, Administrator
Phone: 912-352-3120
Address: 728 E. 67th Street
Savannah, GA 31405

Georgia Department of Community Health:
Phone: (404) 656-4507
Address: 2 Peachtree Street NW, Atlanta, GA 30303 Website: https://dch.georgia.gov

Office for Civil Rights:
U.S. Department of Health and Human Services.
Website: https://www.hhs.gov/ocr

Patient Bill of Rights and Responsibilities

Patients Rights

As a patient in the State of Georgia, you have the following rights, which ensure respectful, informed, and equitable care: Effective 02/11/2015

1. Respect and Dignity

You have the right to be treated with respect, dignity, and courtesy at all times, regardless of race, gender, age, religion, national origin, disability, or sexual orientation.

2. Privacy and Confidentiality

Your medical records and personal information will be kept confidential in accordance with federal (HIPAA) and Georgia state laws. You have the right to access your medical records and request amendments.

3. Informed Consent

You have the right to receive accurate and complete information about your condition, treatment options, and potential risks in a manner you can understand.
You have the right to participate in decisions about your care and to give informed consent before any procedure or treatment.

4. Access to Care

You have the right to receive timely and appropriate medical care.
You may choose your healthcare provider, subject to availability and applicable policies.

5. Refusal of Treatment

You have the right to refuse any treatment or procedure, even if it is recommended by your healthcare provider.
You have the right to be informed of the potential medical consequences of refusing treatment.

6. Second Opinions and Specialist Referrals

You have the right to seek a second opinion or request a referral to a specialist if needed.

7. Pain Management

You have the right to appropriate assessment and management of pain.

8. Advance Directives

You have the right to create advance directives, such as a living will or durable power of attorney for healthcare, and to have them honored by your healthcare providers.

9. Grievances and Complaints

You have the right to express concerns or complaints about your care and to expect a prompt and fair response without fear of retribution.
Complaints may be filed with:

Kate Lyker, Administrator
Phone: 912-352-3120
Address: 728 E. 67th Street
Savannah, GA 31405

Georgia Department of Community Health:
Phone: (404) 656-4507
Address: 2 Peachtree Street NW, Atlanta, GA 30303 Website: https://dch.georgia.gov

10. Financial Information and Billing

You have the right to receive clear, detailed information about your healthcare costs and billing practices.
You have the right to know if your care is covered by insurance and what out-of-pocket expenses you may incur.

11. Non-Discrimination

You have the right to receive care free from discrimination based on race, color, national origin, age, disability, or sex, in accordance with Georgia and federal laws.

12. Research Participation

You have the right to be informed if your care involves research and to refuse participation without compromising your access to care.

13. Continuity of Care

You have the right to continuity of care and to be informed of available services when transitioning between healthcare providers.

Patient Responsibilities

As a patient, you also have responsibilities to help ensure effective, respectful, and safe healthcare. These responsibilities include:

1. Provide Accurate Information

You are responsible for providing accurate and complete information about your health, including past illnesses, hospitalizations, medications, allergies, and any other health-related issues.

2. Follow Treatment Plans

You are responsible for following the recommended treatment plan, including attending appointments, taking medications as prescribed, and following through with medical advice.
If you choose not to follow the plan or refuse treatment, you are responsible for the consequences.

3. Respect for Healthcare Providers and Staff

You are responsible for treating all healthcare providers, staff, and other patients with respect and courtesy.

4. Financial Responsibilities

You are responsible for understanding your insurance coverage and for ensuring that any financial obligations related to your care are met in a timely manner.
You should ask questions about costs, insurance coverage, and payment plans as needed.

5. Ask Questions and Express Concerns

You are responsible for asking questions when you do not understand your diagnosis, treatment, or any instructions provided by your healthcare team.
If you have concerns about your care, you are encouraged to express them promptly to your healthcare provider.

6. Respect Privacy and Facility Rules

You are responsible for respecting the privacy and confidentiality of other patients and adhering to the rules and regulations of the healthcare facility.

7. Advance Directives and Emergency Contact Information

You are responsible for providing copies of any advance directives and updating emergency contact information as needed.

8. Keeping Appointments

You are responsible for keeping scheduled appointments and notifying the clinic as soon as possible if you need to cancel or reschedule.

9. Personal Health and Safety

You are responsible for taking an active role in your healthcare, including managing your lifestyle, diet, and preventive health measures to the best of your ability.