GERIATRIC EYE GROUP

REQUEST FOR EYE CARE (Exam) SERVICES

I _____ hereby request eye care from the Geriatric Eye Group. This consists of an on-site examination by a Geriatric Eye Group doctor who will evaluate and treat the patient for the following: Please circle the reason for the request.

Decreased vision	Diabetic Eye
Cataracts	Retinal degenerations
Glaucoma	Inhaled Steroids (Breathing treatments)
Eye Infections / Red Eyes	Coumadin Therapy
Dry Eye / Eye Pain	Seroquel Therapy

If needed, appropriate referrals will be made to one of our doctors for further evaluation or surgical treatment after consultation with the primary physician and family.

Fee Policy: The Geriatric Eye Group doctors are participating Medicare, Medicaid, Optum, Pruitt Health Premier, Georgia Health Advantage, and ARIA providers. We will assume responsibility for filing insurance claims. If the patient is covered by both primary and secondary insurance there will be no net out-of-pocket expenses.

We agree to allow the Geriatric Eye Group to bill for services.

_____ _____

Resident Name: Date of Birth

_____ _____

Date Admitting Physician

_____ _____

Responsible Party or Resident Facility Name