



Patient Information

PATIENT DEMOGRAPHICS

Date: _____ How did you hear about our office? _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: Male/Female Marital Status: S M W D Email: _____ May we email you? _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone (H): _____ (C): _____ (W): _____

Patient's SSN: _____ Driver's License #: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Patient's Employer: _____ Occupation: _____

Referring Doctor: _____ Phone: _____ Location: _____

Primary Care Doctor: _____ Phone: _____ Location: _____

Payment/Insurance: Self Pay Medical Vision

Primary Medical: _____ Secondary Medical: _____

Subscriber's Name: _____ DOB: _____ Subscriber's Name: _____ DOB: _____

Patient's ID: _____ Patient's ID: _____

Vision: _____ Subscriber's Name: _____ DOB: _____ ID: _____

PARENT, LEGAL GUARDIAN, POWER OF ATTORNEY, SPOUSE

NAME: _____ DOB: _____ RELATIONSHIP: _____

SSN: _____ PHONE (H): _____ (C): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Consent for Treatment: I am the patient or the patient's duly authorized representative, and do hereby, voluntarily, consent to and authorize care encompassing all diagnostic and therapeutic treatment regimens necessary in the judgment of my provider, for myself, my minor child, or other. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatments or performed examinations.

I do, hereby, authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to myself and Jax Vision Care, P.A.

I authorize the following individual(s) to have access to my account and medical information:

*Patient/Legal Representative Signature: _____ DATE: _____



Patient Information

HEALTH QUESTIONNAIRE AND MEDICAL HISTORY

Chief Complaint/Reason for appointment: _____

How long has this occurred: _____

OCULAR (EYE) HISTORY: Last eye examination: _____ Where: _____

if you mark yes for any of the following, please indicate how long:

Glaucoma: Y N _____

Macular Degeneration: Y N _____

Blind/Loss of Vision: Y N _____

Retinal Detachment: Y N _____

Ocular Procedure/Surgery: Y N _____

Cataracts: Y N _____

Ocular Injury(ies): Y N _____

Other/Unknown: Y N _____

Current eye drops, ocular medication or supplements: _____

Have any family members been diagnosed with any eye disease: Y N _____

MEDICAL HISTORY:

Allergies: _____

List ALL surgeries, major illness, hospitalizations with approximate dates:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List ALL medications you are currently taking: Circle if attached: See medication list. Initial: _____

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you: Smoke? Yes, how much for how long? _____ Quit, how long ago? _____ Never

Drink alcohol? Daily Occasionally Rarely Never **Use/take recreational drugs:** Y N Type: _____

- Please check all that apply:**
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sleeplessness | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Migraine | <input type="checkbox"/> Scalp Tenderness |
| <input type="checkbox"/> Sinus/Allergy Problems | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Loss of Hearing |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Any pain |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Numbness | <input type="checkbox"/> Low Iron/Bruise Easily | <input type="checkbox"/> Scar Easily |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Depression |
| | <input type="checkbox"/> Itching/Rash | | |

*Patient/Legal Representative Signature: _____ DATE: _____



Patient Information

JAX VISION CARE, P.A. FINANCIAL POLICY

Thank you for choosing Jax Vision Care as your ocular healthcare provider. We are committed to providing the best medical care possible. Please understand that payment for your services is essential for us to continue to do so. All payment is due at the time services are rendered or materials purchased unless other arrangements are made PRIOR. The following paragraphs explain our financial policies. We will be happy to discuss these with you or answer any questions you may have. Please read, sign and return to the front desk.

INSURANCE

We participate with most insurance plans/policies, including Medicare and Medicaid. For some insurances, we accept assignment of benefits, but in ALL cases, the person responsible for payment (guarantor), is personally liable for all balances or procedures not covered by insurance. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under Medicare guidelines. If you are not insured by a plan that we participate with, or are but do not have an up-to-date driver's license or form of government issued identification and/or a current insurance card, payment in full is required at the time of service. If there are any changes with your insurance coverage, please notify our office as soon as possible PRIOR to your next appointment. Failure to do so could result in payment for services being patient responsibility.

USUAL AND CUSTOMARY RATES

We charge what we believe to be usual and customary rates for our specialty and region to our patients and insurance companies. If your insurance company uses a different fee schedule, you will be responsible for any leftover balance.

CLAIMS SUBMISSION

We file claims to your insurance company for payment as a service to you. We will assist in any way to get your claims paid in a timely fashion. It is your responsibility to comply with any requests from the insurance company regarding information for payment. The contract with the insurance company is between you and the company; we are not party to such contract. If your insurance company does not pay your claims within 45 days, the patient is responsible.

DELINQUENT/PAST DUE ACCOUNTS/ CANCELLATION POLICY

In some instances, we may bill a patient after services are rendered as a courtesy and expect payment within a timely manner. If balances exceed 90 days, the account is considered delinquent or past due and a \$15 billing fee will be added to the current balance. If the account continues in this manner, \$15 will be added to each monthly statement. Accounts with balances exceeding 180 days will be sent to a collection agency and the patient or guarantor will be responsible for all additional fees, including but not limited to agency fees, court costs and attorney's fees. Also, a 1099 will be issued to the IRS for cancellation of debt. Once this step has been taken, Jax Vision Care, P.A. will continue care for 30 days for emergency situations and only on a cash basis. We kindly ask that a 24 hour notice be given for cancellation of an appointment. Failure to do so will result in a \$25 fee to be paid immediately.

CO-PAYMENTS AND DEDUCTIBLES

All co-payments and deductibles are due at the time of service. This is part of your contract with your insurance company. Failure to pay/collect could be considered insurance fraud. If co-pays and deductibles are not paid at the time of service, there will be a \$15 billing fee added to your account that will not be covered by your insurance company.

RETURNED CHECKS

Checks that are returned for any reason will incur a \$15 returned check fee in addition to any fees Jax Vision care, P.A. may incur from the bank. These fees are not covered by insurance and are expected to be paid immediately by cash or credit card to prevent legal action.

I have read and understand the above policies. I have been given the opportunity to ask questions and discuss any discrepancies I may have.

***Patient/Legal Representative Signature:** _____ **DATE:** _____



Patient Information

JAX VISION CARE, P.A. FINANCIAL POLICY, continued...

REFRACTION

Performing a refraction is essential to your exam and vision care. Medicare, along with some other insurance companies DO NOT cover a refraction, but it IS very important in determining your potential vision and in medically diagnosing causes of vision loss.

What is a refraction? A refraction is performed for multiple purposes in an eye exam. It helps with determining your need for glasses or contact lenses. More importantly, it can detect vision loss that a patient may not be aware of due to an unknown condition or problem.

Why is it a separate fee from the exam? Medicare has deemed that a refraction is not a *medical* service and therefore is not covered. Most insurance companies follow Medicare guidelines. Medicare acknowledges that it is a separate service/procedure from the exam and therefore, it has a separate fee.

Do you have to charge for it? YES. The Office of Inspector General has deemed that not charging for a provided service is an "inducement" to the patient and therefore illegal. The Federal Government insists that all services rendered must be charged for. The concern is that some physicians may try to lure or entice patients to their practice versus another by offering free services. We are obligated by the government to charge for all services. The refraction fee is \$30 and is due at the time of service. We will still bill it to your insurance company although payment is not expected. If your insurance pays the refraction or a portion of, your account will reflect that and there will be an appropriate credit.

I have read the above policy and understand that the refraction, **in some cases**, is considered a "non-covered" service and is separate from any other fees associated with my visit. I understand that full payment is due at the time of visit.

***Patient/Legal Representative Signature:** _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

I have been provided the opportunity to read, or have it read to me, the Notice of Privacy Practices at Jax Vision Care, P.A.

I understand that Jax Vision Care, P.A. is committed to treating and using protected health information about me responsibly. I understand how information and records may be used and disclosed. I understand that my health record is the physical property of Jax Vision Care, P.A., but the information belongs to me. I have a right to obtain, inspect, and amend a copy of my health record. Any costs associated with this will be my responsibility and must be paid prior. Written requests must be made to the Privacy Officer. I understand that Jax Vision Care, P.A. is required by law to maintain the privacy of my health information. They will require my written authorization to release my information to outside sources with the exception of disclosures for treatment, payment and healthcare operations. These disclosures may include: access to my information by Jax Vision Care, P.A. staff and doctors; billing to me or a third party; in addition, business associates of Jax Vision Care, P.A. Upon the physicians' best judgment, Jax Vision Care, P.A. may disclose to a family member, relative or close personal friend or any other individual I identify, health information relevant to that person's involvement in my care. Health information may also be used for research data, organ procurement, marketing, FDA, public health or legal authorities and/or law enforcement authorities.

Jax

Vision Care, P.A. may call or write me with appointment reminders, cancellations and may leave voice mail messages at home or place of employment as well as on my mobile phone.

***Patient/Legal Representative Signature:** _____ **DATE:** _____

Witness' Signature _____ **DATE:** _____



Patient Information

CONTACT LENS AND GLASSES POLICIES

Patient (printed) Name: _____

CONTACT LENSES

To provide the best care to our contact lens patients, patient commitment and cooperation are essential. After the initial visit or the start of the fitting process, you are required to return to the office within 2 weeks to have your fit finalized. This is usually a quick visit for your doctor to check the contacts on your eyes.

1. For patients using insurance for any portion of their contacts: After 2 weeks, your exam and fit will be filed to your insurance, most likely exhausting your contacts lens benefits. Please let the staff know of any problems or circumstances that arise preventing you from returning in a 2 week period.
2. Patients may return to finalize their contact lens prescription within 60 days at no additional charge.
3. Patients may return between 60 and 90 days to finalize their contact lens prescription for a \$35 fee.
4. After 90 days the fitting process will start over and the patient will receive 20% off the fitting fee (fitting fees range from \$75-\$125).
5. Any monies paid for fittings, finalized or not, are forfeited.
6. Once contacts are ordered and arrive, we will contact you immediately. Once a patient is notified, contact lenses must be picked up within 90 days. After 90 days, the contact lenses will be returned and any and all monies paid will be forfeited.

*Patient/Legal Representative Signature: _____ DATE: _____

GLASSES (FRAMES AND/OR LENSES)

We are proud to provide our patients with top quality frames and lenses. We strive to order and deliver custom glasses to our patients as quickly as possible. Lenses are made and provided by various optical labs causing various return times. It generally takes about 1-3 weeks from the day glasses are ordered to the day they are ready for patient pick up depending on the lab. Patients are notified immediately when glasses are ready to be picked up.

1. Any orders with patients' responsibility equaling \$100 or less are required to be paid in full prior to ordering the glasses with the labs.
2. Any orders with patients' responsibility equaling \$101 or more, one half of the total must be paid prior to ordering the glasses with the labs.
3. Any orders on hold for payment not completed within 30 days will be returned to inventory and any monies paid will be forfeited.
4. Once an order is started, no changes affecting the finances can be made. All orders are final.
5. Once glasses are ordered and arrive, we will contact you immediately. Once a patient is notified, glasses must be picked up within 90 days. After 90 days, the glasses will be returned and any and all monies paid will be forfeited.
6. The glasses that are provided are custom to each patient, therefore NO REFUNDS shall be given.
7. Jax Vision Care, P.A. (nor any of the optical labs we work with) does not accept any responsibility for damaged or lost frames during the shipping or fabrication process that are provided by the patient. This also includes frames/lenses that may be damaged during the adjustment or repair process at our office or off-site lab.

*Patient/Legal Representative Signature: _____ DATE: _____