# Patient Information

## PLEASE PRINT AND FILL OUT THIS PACKET COMPLETELY

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

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

**Sex: Male/Female Marital Status: S M W D Ethnicity: Hispanic/Latino/Non-Hispanic Race: _____**

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

**Primary phone: _____ Secondary Phone: _____ May we text you? Yes/ No**

**Patient's SSN: _____Email: _____ May we email you? Yes/ No**

**Emergency Contact: _____ Phone: _____ Relationship: _____**

**Patient's Employer: _____ Occupation: _____**

**Referring Doctor: _____ Phone: _____ Location: _____**

**Primary Care Doctor: _____ Phone: _____ Location: _____**

**Payment type:** Self Pay Medical Vision

**Primary Medical: _____ ID#:_____Subscriber's Name:_____DOB:_____**

**Secondary Medical: _____ ID#:_____Subscriber's Name: _____ DOB: _____**

**Vision Insurance: _____ID#:_____Subscriber's Name: _____ DOB: _____**

**PARENT, GUARDIAN, POWER OF ATTORNEY, ETC. (if applicable):**

**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 Information

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

**HEALTH QUESTIONNAIRE AND MEDICAL HISTORY**

**Reason for appointment: _____How long has this occurred: _____**

**Last eye examination: _____Where: _____ Any abnormalities: Yes/No**

**In order to give you the best care possible, please read thoroughly and indicate history or diagnosis of any of the following:**

**OCULAR SYMPTOMS/HEALTH:** ☐Glaucoma ☐Ocular Injuries ☐Difficulty Reading
☐ Retinal Disorders/Detachment ☐Macular Degeneration ☐Difficulty w/ nighttime driving ☐Cataracts
☐ Corneal Disorders/Scarring ☐Dry Eye ☐Eye Pain ☐Eye Fatigue
☐Difficulty w/ computer distance ☐Ocular Surgeries/Procedures: _____
Family History of ocular disease: YES/NO If yes, please explain: _____
Are you currently taking or have you been prescribed eye drops: _____
Have you been under the care of any other eye doctor within the last year: YES/NO If yes, Dr's name and reason: _____
_____

**OVERALL HEALTH**: ☐Diabetes ☐High Cholesterol ☐High Blood Pressure ☐Excessive Thirst
☐Any Cancer ☐Stroke ☐Lupus ☐Seizures ☐Headaches/Migraines
☐Jaw Pain ☐Chest Pain ☐Dizziness/Fainting ☐Poor Circulation ☐Sinus/Allergies
☐Sleep Apnea ☐Fever(currently) ☐Unexplained Weight Loss ☐Frequent Urination ☐Scalp Tenderness
☐Loss of Hearing ☐Depression ☐Thyroid Condition ☐Crohn's Disease ☐Multiple Sclerosis
☐Sjogren's Disease ☐Herpes ☐Shortness of Breath ☐Sarcoidosis ☐Irregular Heartbeat
☐Numbness ☐COPD ☐Pregnant (currently) ☐Breast feeding (currently) ☐Aids/HIV
☐Rheumatoid Arthritis ☐Low Blood Pressure ☐Difficulty Swallowing

**List any Allergies to MEDICATION: _____**

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

**1. _____ 2. _____**

**3._____ 4. _____**

**5. _____ 6. _____**

**Do you: Smoke? NO YES,** how much for how long? _____ Quit, how long ago? _____

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

****New patients will be dilated during the first visit. Dilation could cause light sensitivity and blurriness.**

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

**OFFICE USE ONLY:**

# Patient Information

**Name: _____ DOB: _____ ACCT #: _____ Appt time: _____ NP/EST OPTOS**

**RETURN IN: _____ DAY(S) WEEK(S) MONTH(S) YEAR(S) CODES: _____**

**VF GDX PACHY OCT/MAC OCT CL F/U IOP CK DFE RED EYE F/U CORNEA CK VISION CK POST OP RX F/U**

**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**

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 you 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.

**PERSONAL CHECKS**

***AS OF January 1st, 2019, Jax Vision Care will no longer accept checks from patients.** Prior to that, checks that are returned for any reason will incur a $45 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. All visits will be postponed until the account is current.

*** 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: _____**

**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 $35 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: _____

## PLEASE READ CAREFULLY!!

### 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). It will be at the doctor's discretion if a new exam will be needed.
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.

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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.
8. **There are fees** for adjustments, prescription checks, measurements, etc for glasses not purchased at our office (online, another optical store, etc).

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