Jones Eye Care and Surgery, Inc.   Patient Information

Appt . Date ________________________ Physician: Theresa E. Jones, MD   / Kimberly A. Layfield, OD

Patient Last Name: ___________________________ **First Name**: ___________________________ **Middle**: ________

Address: ____ **City** ______________________ **State** _________

Zip _____________   **Social Security #** ________________________   **Date of Birth** ___________________

Home Ph (   ) ____________________ **Cell Ph** (   ) __________________ _   **Work Ph** (   ) __________________

Marital Status ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Other ________________________

Sex: ☐ Male ☐ Female   **Primary Language**: ☐ English ☐ Spanish ☐ Other ____________________

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ African American/Black

☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other ☐ Decline to Answer

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

E-Mail Address: ____

Employer/School: _____________________ ______________   **Occupation**: _______________________________

Emergency Contact: ____Phone (   ) _________________________

Primary Care Physician _______________________________________ Phone (   ) _________________________

Referring Physician ____ Phone (   ) _________________________

Person Responsible _____________________________________ Relationship ______________________________

Address (if different than above) _______________________________City ___________________ State __________

Zip ___________ Phone (   ) _____________________Employer_______________________________________

Phone (   ) ___________________Social Security # _____________________ Date of Birth ___________________

Pharmacy Information: **Name**: ____

Phone:_______________________________________Fax:_____________________________________

Insurance Information: *You must provide us with a current copy of your insurance card(s).*

Primary Insurance: ________________________________ ID# ________________________________

Group # __________________________ Policy Holder ____________________________________

Date of Birth _______________ Social Security # __________________ Relationship to Patient _____________

Secondary Insurance: ________________________________ ID#______________________________

Group # __________________________ Policy Holder ____

Date of Birth _______________ Social Security # __________________ Relationship to Patient _____________

Vision Insurance ____

(OVER)

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider.

Signature: ____**Date:**_______________

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We will only file to one secondary policy.

Medicare Authorization

I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HICFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: ____**Date:**_______________

Financial Contract Agreement

Jones Eye Care and Surgery, Inc. is committed to your successful treatment. Please understand that payment of your account is considered a part of your treatment. If you do not have your current insurance card at the time of service you will be treated as a "self-pay" patient.

All co-pays are due prior to seeing the physician (we accept Cash, Checks, MasterCard, Visa, & Discover)

All "self pay" patients are asked to pay this visit fee in full at the time of service unless other prior arrangements are made.

All patients covered under an HMO plan must have a valid referral at the time of their visit

All delinquent accounts, 30 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees, along with a $25 administration fee.

We do not get involved with any litigation accounts, disputed workmens' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements with our Practice Administrator.

The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account.

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Your insurance is a contract between you and the insurance company. We are not a party to that contract or know exactly what benefits are included or excluded in your plan. Please be aware that some, and perhaps all of the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information. You are fully responsible for verifying the benefits of your policy.

If you have no insurance coverage and need financial help, our Business Office personnel will be happy to help you work out an agreeable payment plan. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. Please let us know if you have any questions or concerns. I understand and agree to this Financial Contract Agreement as stated above:

Signature: ____**Date:**______________

Receipt of Notice of Privacy Practices/Written Acknowledgement Form

I have received a copy of Jones Eye Care and Surgery, Inc. Notice of Privacy Practices dated 09/23/2013

Signature: ____**Date:**______________

The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.

Jones Eye Care and Surgery, Inc.
Medical History Form

Name ____ Date ____________________

Patient Social History: *(Please circle the applicable answer)*

Use of Alcohol: Never Rarely Moderate Daily If so, how much ______________________

Use of Tobacco: Never Previously/Quit (date) ___________ Current Packs/day _________

Patient Ocular History: (Please list any Ocular History/Surgeries (including Eye/Surgeon/Date)

☐ Glaucoma ☐ Cataracts ☐ Lazy/Crossed Eye ☐ Macular Degeneration ☐ Retina Detachment

☐ Other ____

____

Patient Medical History: (Please list any Medical History/Surgeries (include Date/& Description of Surg.)

____

____

____

Medications: (Please list any prescription or non-prescription medications/ Please include dosage.)

____

____

____

Are you ALLERGIC to any Medications: NO / YES, (If yes, list medication(s).

____

____

Have you ever taken the medication FLOMAX/ TAMSULOSIN? NO / YES *(Please circle)*

Are you ALLERGIC to LATEX?: NO / YES *(Please circle)*

Patient Family Health History: *(Has anyone in your family been told they have).*

- ☐ Glaucoma Who?______________________ _
- ☐ Heart Disease Who? _______________________
- ☐ Cataracts Who? _______________________
- ☐ Diabetes Who? ________________________
- ☐ Crossed/Lazy Eye Who? _________________
- ☐ Cancer Who? __________________________
- ☐ Macular Degeneration Who? __________________
- ☐ Other ______________________________________