Welcome to JEFFRIES EYE CARE! Please complete the following form in its entirety.

Date: _____

Name: Last: _____ First: _____ M.I.: _____ Salutation: _____

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

Date of Birth: _____ Age: _____ Home Phone: _____ Cell Phone: _____

SS# _____ Marital Status: _____ E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

**How were you referred to our office?**

O Friend or Family Member: _____ O Insurance Company O Television

O Family Doctor: _____ O Received mailing O Newspaper

O Ophthalmologist: _____ O Internet O Other

**Please list all insurances, vision and medical. Please bring all insurance cards with you to your appointment.**

| VISION INSURANCE | PRIMARY MEDICAL INSURANCE |
|---|---|
| Ins. Co. Name: | Ins. Co. Name: |
| Address: | Address: |
| | |
| Insured's Name: | Insured's Name: |
| Identification#: | Identification#: |
| Group#: | Group#: |
| Insured's DOB: | Insured's DOB: |
| Insured's SS#: | Insured's SS#: |
| Patient Relation to Insured: | Patient Relation to Insured: |

| SECONDARY MEDICAL INSURANCE | Group #: |
|---|---|
| Ins. Co. Name: | Insured's DOB: |
| Insured's Name: | Insured's SS#: |
| Identification#: | Pation Relation to Insured: |

**I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company(ies) and assign directly to Amy Jeffries, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

Responsible Party Signature: _____ Date: _____

## EYEGLASS HISTORY

Do you wear glasses? O Yes O No O Full Time O Part Time O Distance O Near

Glasses Owned: O Single Vision O Bifocals O Trifocals O Progressive O Backup Glasses O Safety Glasses O Sports Glasses O Other

Computer Used: O Yes O No Hours per day: Distance from computer:

Do you have problems with glare? O Yes O No

Do you have problems with night vision? O Yes O No

Are you allergic to nickel (eg: jewelry or eyeglass frames discoloring your skin)? O Yes O No

If you currently wear eyeglasses, are there certain times when you would rather not? O Yes O No

If you currently wear eyeglasses, does your spare pair have the correct prescription? O Yes O No

Do you wear prescription or non-prescription sunglasses? O Yes O No

Do your sunglasses have UV (ultra-violet) protection? O Yes O No

Are your sunglasses your current prescription? O Yes O No

## CONTACT LENS HISTORY

Do you currently wear contact lenses? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping: _____

If you wear contact lenses, do your backup eyeglasses have your correct prescription? O Yes O No

**Answer the questions below only if you currently wear contact lenses:**

1. What type or brand of contacts do you wear? _____
2. How old are your contact lenses? _____
3. How often do you replace or dispose of your contact lenses? _____
4. What brand of solution do your lenses soak in overnight? _____
5. What is your typical wearing schedule? _____ Hours/day _____ Days/week
6. Are you having any problems with your current contact lenses? O Yes O No

Are you interested in being evaluated for refractive surgery? O Yes O No

Are you interested in wearing contact lenses? O Yes O No

Date of last eye exam: _____ Where did you get your last eye exam? _____

Date of last physical exam: _____ Name of Primary Care Physician: _____

## MEDICAL HISTORY

**Eye History:** Do you suffer from any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Distance vision blur | O Yes O No | Seeing flashes | O Yes O No | Dry Eyes | O Yes O No |
| Near vision blur | O Yes O No | Distorted vision (haloes) | O Yes O No | Itching | O Yes O No |
| Middle distance vision blur | O Yes O No | Glare / Light sensitivity | O Yes O No | Red Eyes | O Yes O No |
| Double Vision | O Yes O No | Loss of side vision | O Yes O No | Crossed Eyes | O Yes O No |
| Mucous Discharge | O Yes O No | Eye pain / soreness | O Yes O No | Headaches | O Yes O No |

**Review of Systems: Many diseases of the body have grave eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.**

| Do you currently have any of the following problems? | Yes | No | If YES, please explain: |
|---|---|---|---|
| Chronic fever, unexpected weight loss/gain, fatigue..... | O | O | _____ |
| Ear/nose/throat problems (eg hearing loss, sinus problems, sore throat)..... | O | O | _____ |
| Heart problems (eg chest pain, irregular heart beat, swelling of feet, cold hands or feet) | O | O | _____ |
| Respiratory problems (eg shortness of breath, wheezing, coughing)..... | O | O | _____ |
| Gastrointestinal problems (eg heartburn, abdominal pain, diarrhea, vomiting)..... | O | O | _____ |
| Genitourinary problems (eg painful urination, blood in urine, sex organ problems)..... | O | O | _____ |
| Musculoskeletal problems (eg muscle aches, joint pain, swollen joint)..... | O | O | _____ |
| Skin problems (eg rashes, excessive dryness, growths or lumps)..... | O | O | _____ |
| Neurological problems (eg numbness, weakness, headaches, "blackouts")..... | O | O | _____ |
| Psychiatric problems (eg depression, anxiety)..... | O | O | _____ |
| Endocrine problems (eg frequent urination, thirst, feeling hot or cold all the time)..... | O | O | _____ |
| Blood/Lymph problems (eg bruising, weakness, unusual paleness, swollen glands)..... | O | O | _____ |
| Immune problems (eg frequent infections, allergic reactions to foods, dust, pollens)..... | O | O | _____ |

Have you ever been treated for any medical conditions? (eg diabetes, high blood pressure, high cholesterol, arthritis, etc) O Yes O No

If YES, please explain: _____

Have you ever had any eye disease? (eg glaucoma, cataract, wandering or "lazy" eye, retinal detachment) O Yes O No

If YES, please explain: _____

Have you ever had any surgery or been hospitalized? O Yes O No

If YES, please explain: _____

Do you take any medication, including over the counter medicines? O Yes O No

If YES, please explain: _____

Do you have any food or drug allergies? O Yes O No

If YES, please explain: _____

**Family History:** Do any MEDICAL or EYE disease run in your family (BLOOD relatives) (eg diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? O Yes O No

If YES, please explain: _____

**Social History:**

Do you drink alcohol? O No O Occasionally O 1 / day O 2-3 /day O 4+ /day

Do you smoke or use tobacco products? O No O Occasionally _____ pack(s) / day

**HIPAA Protected Health Information: It is the policy of this office in accordance with the Federal HIPPA Regulation that all health information is kept strictly confidential. Please sign below in recognition that a copy of our protected health information privacy act was given to you for your review.**

Signature: _____

**Below For Office Use Only:**

**I have reviewed this information with the patient.** _____ O.D. Date: _____

Reviwed on the following dates: Initials _____ Date: _____ Initials _____ Date: _____

# JEFFRIES EYE CARE FINANCIAL POLICY

*Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between you, the patient and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.*

1. Although our office will bill your insurance company, it is necessary for the patient to fill out all of the insurance information form completely. If the form is not completed, or you do not know who your insurance is with, we will not be able to appropriately bill the insurance company and the responsibility for payment then becomes that of the patient.

2. The patient will pay the **estimated** co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.

3. Insurance plans are categorized as either a **Medical** or as a **Vision** plan. A vision plan often covers a routine exam for glasses or contacts. A medical plan covers and exam for eye or vision problems. The reason for your visit, as well as the nature of your exam, will determine which insurance plan is filed.

4. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 90 days, we will require the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.

5. Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.

6. Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

7. If you do not have insurance, or we do not participate with the insurance plan, payment for an office visit is due at the time of service. We accept cash, checks, and most major credit cards. Any returned checks will carry a returned check fee of $40.

8. Patient balances are bill immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 15 business days of your receipt of bill. If previous arrangements have not been made, any account over 60 days will be forwarded to a collections agency.

If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment.

Signature of Patient Date

**NOTICE OF PRIVACY Acknowledgement of Receipt of Privacy Notice**

The Health Insurance Portability and Accountability Act (**HIPPA**) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at **Jeffries Eye Care.,** we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. **This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, process health insurance claims, or mail exam recalls.**

By signing below, I acknowledge that I have read/receive the copy of the Notice of Privacy Practices for review.

Signature of Patient or Legal Representative Date