CREDIT POLICY AND FINANCIAL AGREEMENT

- Each patient, and not their insurance company, is responsible for the payment of all charges. Payment is customarily made at the time that services are rendered, unless special arrangements are made in advance. If one of our doctors is a participating physician for your primary insurance plan, payment for any deductibles, co-pay amounts and non-covered services will be due at the time of service.

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services that you receive in our office. It is simply not possible for the staff of this office to know how each and every individual insurance plan works.

- A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically not a covered benefit of your insurance plan. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.

- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services would be: the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by a supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States congress, prohibits this office from extending courtesy discounts and/or professional write-offs.

- Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings.

- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney’s fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suite.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to J. Gregory Jones, M.D., P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance.

I hereby authorize J. Gregory Jones, M.D., P.C., to release any and all information necessary to secure payment.

Signed __________________________________________ Date ______________________________
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers' Compensation: We may release information about you for Worker's Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may request that we communicate with you confidentially, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the U. S. Department of Health and Human Services.

You will not be penalized in any way for filing a complaint.

I, __________________________________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: ________________________________________

Date: __________________________________________

If not signed, reason why acknowledgment was not obtained:

______________________________________________
NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use your health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
FINANCIAL AGREEMENT
I hereby assume full responsibility for all charges incurred for professional service rendered by J. Gregory Jones, M.D., P.C. unless the services are deemed "PAID IN FULL." as a result of a contractual agreement between J. Gregory Jones, M.D., P.C. and my insurer.

I.  AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize J. Gregory Jones, M.D., P.C. to release any medical, psychiatric, infectious disease, or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits (now and with whom I may apply for benefits within the future) for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bill related to my treatment have been paid. I further understand that I can withdraw (a written notice) this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance heron.

II. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT BENEFITS
I authorize my health insurance benefit plan to pay directly to J. Gregory Jones, M.D., P.C. the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claims but not to exceed the charges for those services. I understand I am financially responsible to J. Gregory Jones, M.D., P.C. for charges NOT covered by this agreement.

III. MEDICARE, CLAIM INFORMATION AND PAYMENT REQUEST
I authorize any holder of medical information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Relations pertaining to Medicare assignments of benefits apply.

IV. COLLECTIONS
I understand that after 60 days of non-payment the claim/charge is my responsibility. It is then my (the patient) responsibility to contact the insurance company about the unpaid claim/charge. If my (the patient) bill is not paid in the next 30 days, my account can be turned over to collection and an additional fee ($10.00-$50.00) can be added to the charge.

V. APPOINTMENTS
I understand that if I am ever 15 minutes or more late for an appointment, my appointment will be rescheduled as not to inconvenience other patients. I understand that if this should happen frequently, that I can be charged a $20.00 no show fee. I understand that if for some reason I do not show up for an appointment or cancel within 24 hours of my scheduled appointment, I will be charged a $20.00 no show fee.

Signature _________________________ Date _________________________
J. Gregory Jones, M.D., P.C.
(478) 741-1740 • (478) 745-2887

PATIENT INFORMATION

Mr. Mrs. Miss MS: ________________________________

First Middle Last
Marital status: Married [ ] Single [ ] Divorced [ ] Widowed [ ]

Home Phone: ___________________________ Cell Phone: _______________________

Street Address: ____________________________________________________________

Mailing Address: __________________________________________________________

City: ___________________________ State: ___________ Zip: ________________

Social Security Number ___________________________ Date of Birth ________________

Employer: ___________________________________ Work # ____________________

Person Responsible for bill: ____________________________ Address: ________________ Phone #: __________________

Spouse/Parent Name ____________________________ Spouse/Parent Social Security # __________________________ Date of Birth ________________

Spouse/Parent Employer ___________________________ Phone #: __________________

Address of employer: ______________________________________________________

Nearest relative not living with you: __________________________________________

Address ____________________________ Phone #: __________________

Insurance: 1. ____________________________ Policy number ______________________

Subscriber: ____________________________ Group number ______________________

2. ____________________________ Policy number ______________________

Subscriber: ____________________________ Group number ______________________

How did you hear about us? TV [ ] Radio [ ] News Paper [ ] Word of mouth [ ]
Yellow Pages [ ] Other ____________________________
Medical History Questionnaire
(Please print clearly and use the back of this page if you need more space)

Today's date: _______________________
Name: ____________________________
Your age: ______ Your birthplace: ____________________________
Who is your medical doctor? ____________________________
What is the main reason for your visit today? ____________________________

What Pharmacy do you use? ____________________________

Do you have any of these eye symptoms?
☑ Blurred distance vision  ☐ Glare, halos around lights
☑ Blurred reading vision  ☐ Itching or burning eyes
☑ Constant double vision  ☐ Eye mattering or tearing
☑ Flashing lights or floaters  ☐ Foreign body sensation
☑ Red Eyes  ☐ Dry Eye  ☐ Eye Pain

Do you have any allergies to any medications?
☐ None known  ☑ Yes, which ones? (list below)

Medication Name  What reaction did you have?
________________________________________________________
________________________________________________________
________________________________________________________

Which eye medications do you currently take?
☐ None  ☑ Artificial Tears

Medication Name  Amount  How many times/day
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime

Which other medications do you currently take?
☐ None  ☑ Aspirin on a daily basis?

Medication Name  Amount  How many times/day
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime
1 2 3 4 at bedtime

Have you ever had any of these eye problems?
☐ Cataract  ☐ Serious eye injury
☐ Glaucoma  ☐ Influenza/uvulitis
☐ Macular degeneration  ☐ Lazy eye
☐ Wore eye patch as a child  ☐ Retinal detachment
Other: ____________________________

Have you ever had any of these conditions? If Yes, explain.
☐ None
☐ Stroke  ☐ Dizziness  ☐ High blood pressure
☐ Arthritis  ☐ Allergies  ☐ Heart disease
☐ Diabetes  ☐ AIDS, HIV  ☐ Lung disease
☐ Cancer  ☐ Anemia  ☐ Thyroid disease
☐ Headaches  ☐ Other: ____________________________

Have members of your family had any eye diseases?
(This would be your father, mother, sister, brother, grandparents)
☑ Glaucoma  ☐ Diabetic eye disease or diabetes
☑ Cataract  ☐ Crossed eyes  ☐ Macular degeneration
☑ Influenza/uvulitis  ☐ Blindness  ☐ Retinal detachment
☐ Poor Vision  ☐ Other: ____________________________

Please list any eye surgeries you have had:
☐ None

Type of Eye Surgery  Which Eye  Year
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Please list any other surgeries you have had:
☐ None

Type of Surgery  Year
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

What non-surgery illness have caused a hospital stay?
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

If you have glaucoma:
In what year was the diagnosis first made? ____________________________
Month and year of your last visual field test? ____________________________
Name of your previous ophthalmologist? ____________________________

Do you use?  ☐ Tobacco  ☐ Alcohol

What was the approximate date of your last eye examination: _________________