

**FINANCIAL RESPONSIBILITY** I understand that all services rendered to \_\_\_\_\_ are my financial responsibility and that payment is due at the time of treatment unless prior arrangement has been made. I accept full responsibility for payment of any services not covered by my insurance carrier. I agree to pay collection fees, court costs, and attorney fees if legal actions are necessary for collection of this account.

**RELEASE OF MEDICAL INFORMATION** Tammy Holsclaw-Jones, OD may disclose all or any part of my medical record and/or financial ledger, to my insurance companies, any third party healthcare provider rendering treatment on my behalf, my attorney if liability related, or Employer and their Workman’s Compensation carrier if a job related injury.

**MEDICARE** I agree that payment of authorized Medicare benefits be made either to me or on my behalf to Tammy Holsclaw-Jones, OD for any services furnished to me by Tammy Holsclaw-Jones, OD. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the Medicare claims for services provided by Tammy Holsclaw-Jones, OD.

**MEDIGAP** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 from, or elsewhere on other approved claims forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Tammy Holsclaw-Jones, OD.

**OTHER INSURANCE** I hereby Authorize Tammy Holsclaw-Jones, OD to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Tammy Holsclaw-Jones, OD and direct my carrier or its intermediaries to issue payment directly to Tammy Holsclaw-Jones, OD. I understand I am financially responsible to Tammy Holsclaw-Jones, OD.

**NON-COVERED SERVICES** \_\_\_\_\_ **PATIENT INITIAL** I understand that Medicare and most commercial insurance carriers do not pay for a Refraction. Refraction is the procedure which determines your best corrected visual acuity and will assist your physician in diagnosis of eye disease as well as to prescribe new glasses. Because it is difficult to reliably assess vision in children, a refraction is an integral part of the pediatric exam and is necessary to assess the health of the child’s eye. In most instances, this is a required portion of your eye exam, your Physician and/or Technician will determine this. A fee of \$14.99 is due at the time the service is rendered.

Other services or supplies may be considered non-covered by my health plan. I accept full responsibility for all items or services, which are determined by my health care plan not to be covered.

**PRIVACY POLICY AND PRACTICES** I understand in an attempt to protect the privacy of my identifiable health information, Tammy Holsclaw-Jones, OD has established a privacy policy and guidelines for privacy practices within other office(s). This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment, and health care operations. In accordance with HIPPA regulations, a copy of the Privacy Policy and Practices of Tammy Holsclaw-Jones, OD has been made available to me while in the office today. Should I choose to have a personal copy, then one will be given to me at no charge.

- ( ) I have read, understand, and acknowledge the Privacy Policy and Practices of Tammy Holsclaw-Jones, OD.
- ( ) I have elected NOT to read the Privacy Policy and Practices of Tammy Holsclaw-Jones, OD.
- ( ) A copy of the Privacy Policy and Practices of Tammy Holsclaw-Jones, OD was given to me today.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

# Tammy Holsclaw Jones OD

## PATIENT HISTORY AND INFORMATION

Patient Name \_\_\_\_\_ Date of Service \_\_\_\_\_

### Visual History

Current Occupation: \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

Do you use a computer? ( ) Yes ( ) No

How many hours/day \_\_\_\_\_

Distance from Computer \_\_\_\_\_

Do you have visual difficulty when driving? ( ) Yes ( ) No

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### Spectacle Lens History

Do you currently wear glasses? ( ) Yes ( ) No

Since \_\_\_\_\_

Type of glasses ( ) Full Time ( ) Part Time ( ) Distance ( ) Close

Glasses Owned ( ) Single Vision ( ) Bifocals ( ) Trifocals ( ) Backup ( ) Safety ( ) Sports ( ) Progressive

Have you had trouble in the past with glasses? ( ) Yes ( ) No

Do you wear sunglasses? ( ) Yes ( ) No

Are your sunglasses your current prescription? ( ) Yes ( ) No

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### Contact Lens History

Have you ever tried to wear contact lenses? ( ) Yes ( ) No

Reason for stopping \_\_\_\_\_

Do you currently wear contact lenses? ( ) Yes ( ) No

Since \_\_\_\_\_

Type and brand of contact lenses \_\_\_\_\_

Today's wearing time? \_\_\_\_\_

How many hours/day? \_\_\_\_\_

How many days/week? \_\_\_\_\_

What solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left

Right Left

Right Left

Lens Comfort: \_\_\_\_\_ Distance Vision: \_\_\_\_\_ Near Vision: \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time? ( ) Yes ( ) No

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### Social History

Do you use nutritional supplements (vitamins, etc.)? ( ) Yes ( ) No

Do you engage in regular exercise? ( ) Yes ( ) No

Do you drink alcohol? If yes, how much/often: ( ) No ( ) Occasional ( ) 1/day ( ) 2-3/day ( ) 4+/day

Do you smoke? If yes, how much/often: ( ) No ( ) Occasional ( ) 1/day ( ) 2-3/day ( ) 4+/day

Hobbies/Interests: \_\_\_\_\_



