JAMES RIVER
EYE PHYSICIANS, P.C.

FINANCIAL POLICY

- **Payment is due when services are provided. We accept cash, checks and VISA, Mastercard, Discover or American Express.**

- **You may have health insurance that may pay a portion of your bill. As a courtesy to you we will file your claim if we are a Participating Provider for your insurance plan. We participate with most insurance carriers. Please call our insurance department for more information. 595-8404**

- **You are responsible *at the time of your* visit for:**

  - **Co-payments/ Co-insurance**
  - **$45.00 Refraction charge if applicable**
  - **Contact lenses fitting fee if applicable**
  - **Supply of contact lenses if applicable**
  - **Minimal $50 as *partial* payment for high deductible plans**
  - **Any balances on your account**

  ***** At your first appointment, as well as *some* future visits, part of your exam will be to determine your best vision, with correction if necessary. This is a refraction and consists of testing your vision by looking at an eye chart through lenses that can be changed to assist you to see as clearly as possible. This diagnostic test assists the doctors in determining if you have any disorders or eye diseases causing a decrease in vision or if your vision can be corrected by a prescription for glasses or contact lenses. For most insurance companies including Medicare, a refraction is a *non-covered service* which you must pay in addition to any co-pays *at the time of service.* *If the refraction is not paid for at the time of service, we will hold all copies in the chart until it is paid in full.***

- **We do not charge for copies of your written glasses prescription if you have had a refraction in the last year. We try to give our patients a new prescription at least once a year even if there is no change in their vision. This allows you to have a current prescription in the event you break your glasses, purchase an extra pair, or add or replace sunglasses.**

- **Returned check charges are $25.00. If it becomes necessary to place your account with a Collection Agency, there will be additional charges added to your account. I have read and understand the above policy.**

- **Signature of Patient/Responsible Party_____ Date_____**

IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

OFFICE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	SEX	MARITAL STATUS	DATE OF BIRTH	AGE	EMPLOYER
( )	☐ M ☐ F	☐ S ☐ D ☐ M ☐ W			

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

CELL PHONE	WORK PHONE	EMAIL	OCCUPATION
( )	( )		

I WAS REFERRED TO THIS PRACTICE BY: ☐ Dr. _____ ☐ Family ☐ Friend ☐ Other _____

RESPONSIBLE PARTY (*SKIP IF SAME AS ABOVE*)

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.

ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	HOME PHONE	WORK PHONE	EMAIL	OCCUPATION	EMPLOYER
	( )	( )			

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

SPOUSE

SPOUSE'S NAME	SPOUSE'S SS#	SPOUSE'S EMPLOYER

EMERGENCY

EMERGENCY CONTACT	RELATIONSHIP	DAYTIME PHONE
		( )

INSURANCE

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

INSURANCE CO. #1		INSURANCE CO. #2	
INSURANCE NAME		INSURANCE NAME	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
ID NO.	SUBSCRIBER'S SOCIAL SECURITY NO.	ID NO.	SUBSCRIBER'S SOCIAL SECURITY NO.
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT	SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by the physicians of James River Eye Physicians and/or any affiliated medical staff member(s). I authorize direct payment from my insurance carrier to this practice. I accept responsibility for payment of all charges incurred as well as reasonable attorney's fees and any other related costs of collection of 33⅓% should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE

MEDICARE PATIENTS ONLY

IF YOU ARE A MEDICARE PATIENT, THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.

I request that payment of authorized Medicare benefits be made on my behalf to James River Eye Physicians, P.C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim from is completed, my signature authorizes releasing of the 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT SIGNATURE	DATE

James River Eye Physicians, P.C.

Notice of Privacy Practices

Patient _____

I would like the following individuals to have access to my medical information:

1. _____ Primary Care Physician
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

_____ I would like all medical information pertaining to my care at James River Eye Physicians, P.C. to remain confidential.

Patient Signature: _____

Date: _____

Last four digits of Social Security Number: _____

Staff Initials: _____

James River Eye Physicians, P.C.

PATIENT ACKNOWLEDGEMENT FORM

By signing this form, you acknowledge you have had the opportunity to review the *Notice of Privacy Practices* of James River Eye Physicians, P.C. in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

Acknowledgement signature _____

Printed name – Patient or Representative _____

Relationship to Patient (if other than patient) _____

Date: _____

In front of _____
Printed name of Practice representative

JAMES RIVER
EYE PHYSICIANS, P.C.

PATIENT HISTORY RECORD

DATE

REFERRED BY	PRIMARY CARE PHYSICIAN	PREVIOUS EYE DOCTOR	
PATIENT NAME		BIRTHDATE	SEX ☐ M ☐ F / AGE
ADDRESS			HOME PHONE
EMPLOYER	OCCUPATION		WORK PHONE

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY

1.	Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc.)	☐ Yes ➡ Please explain ☐ No
2.	Have you ever had any eye disease? (e.g. glaucoma, cataract, "lazy" eye, retinal detachment,	☐ Yes ➡ Please explain ☐ No
3.	Have you ever had any surgery?	☐ Yes ➡ Please explain ☐ No
4.	Have you ever been hospitalized?	☐ Yes ➡ Please explain ☐ No
5.	Do you take medications? (including eye medications)	☐ Yes ➡ Please explain ☐ No
6.	Do you have any food or drug allergies?	☐ Yes ➡ Please explain ☐ No

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, fatigue			
Ear / nose / throat problems (e.g. hearing loss, sinus, sore throat)			
Heart problems (e.g. chest pain, irregular heart beat)			
Respiratory problems (shortness of breath, wheezing, coughing)			
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)			
Urinary problems (pain or discomfort, blood in urine)			
Skin problems (rashes, excessive dryness)			
Musculoskeletal problems (muscle aches, joint pain)			
Neurologic problems (numbness, weakness, headaches)			
Psychiatric problems (depression, anxiety)			

FAMILY & SOCIAL HISTORY

Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma, macular degeneration) ☐ No ☐ Yes ➡ Please explain

Do you smoke? ☐ Yes ➡ How much? ☐ No

Do you drink alcohol? ☐ Yes ➡ How much? ☐ No

If employed, how many hours per week do you work?

COMMENTS

MD SIGNATURE

DATE