CHARLES P. ADAMS, JR., MD, P.A.
BRITTANY RANSOM AGEE, M.D.

PATIENT INFORMATION FORM

Date: _____

Patient Information:

Last Name:	Home Phone:
First Name: MI:	Work Phone:
Address:	Cell Phone:
City, State, Zip:	Social Security #:
Sex: □Male □Female	Drivers License #:
Date Of Birth:	Marital Status: □M □S □D □W
Employer:	Occupation:
Email:	

Policyholder Information if not patient:

Last Name:	Home Phone:
First Name: MI:	Work Phone:
Address:	Social Security#:
City, State, Zip:	Date Of Birth:
Employer:	Marital Status: □M □S □D

Emergency Contact:

Name:	Relationship:
Phone#:	
Whom May We Thank for Referring You?	Name:

Social History:

Do You Smoke?	How Many Packs A Day?
Do You Drink Alcoholic Beverages?	How Often?

Medical Health:

Have you ever had:	(CIRCLE ONE)		Hay fever?		
Heart Disease or disorder?	YES	NO	Asthma?	YES	NO
Thyroid Disease?	YES	NO	Bad headaches?	YES	NO
Abnormal Blood Pressure?	YES	NO	Eye injury?	YES	NO
Hepatitis?	YES	NO	Crossed eye?	YES	NO
Tuberculosis?	YES	NO	Cataracts?	YES	NO
Diabetes?	YES	NO	Glaucoma?	YES	NO
Epilepsy?	YES	NO	Other eye problems?		
Arthritis?	YES	NO	Any drug allergies?		
Stroke?	YES	NO	If yes, please list:		
Other significant health problems?			History of **FLOMAX use?**		
Pharmacy:			Pharmacy Phone #:		
Primary Care Doctor:			Primary Care Doctor Phone:		
			Primary Care Doctor Fax:		

List of medications you are currently taking:

_____

_____

_____

_____

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It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file your insurance. However, **YOU** are responsible for all copays, deductibles and non-covered services at the time of service.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided on the patient information form is true and correct to the best of my knowledge. I will notify you of any changes in this information. A photo copy or other reproduction of this will be valid as the original.

Date: _____ **Signature:**_____
(Responsible party if a minor)

AUTHORIZATION TO RELEASE INFORMATION

- I hereby authorize Dr. Charles P. Adams, JR., MD, PA or Dr. Brittany Ransom Agee, MD to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents all information with regard to my medical care.

Date: _____ **Signature:**_____
(Responsible party if a minor)

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize payment directly to Dr. Charles P. Adams, JR., MD, PA or Dr. Brittany Ransom Agee, MD for medical benefits, if any, otherwise payable to me under the terms of my insurance.

Date: _____ **Signature:**_____
(Responsible party if a minor)

1034 Riverside Avenue, Jacksonville, FL 32204 • 1411 S. 14th Street, Suite G, Fernandina Beach, FL 32034
Telephone: (904) 354-2114 • Fax: (904) 354-2122

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Refraction Policy

Welcome to Dr. Charles Adams & Dr. Brittany Ransom Agee's office. We are happy to have you as a patient. Performing a refraction is an intrical part of your examination with our doctors. While Medicare and some major insurance carriers do not cover this test, it is often a necessary part of the examination to determine your visual acuity.

Frequently Asked Questions About Refractions (FAQ)

1) **What is a Refraction, and why do you charge for it?**
Often a refraction is used to determine your need for glasses, but it is also used to detect vision loss. Vision loss can be slow and progressive and sometimes the patient may not notice these changes. These changes are detected by refracting the eye and can uncover the cause of the problem. This test is intrical to determining a patient's eye heath.

2) **Why is this charge separate from the exam?**
Medicare has determined that a refraction is ***not*** a medical service and therefore not a covered service. Medicare does acknowledge that this is separate to the rest of the eye exam and therefore there is a separate fee for this service. Most insurance companies have followed Medicare's lead and do not cover the refraction, because they consider the test to be "vision care" and unrelated to the office visit. The problem is that occasionally this is the only way to detect some types of vision loss.

3) **Does Dr. Adams have to charge for the refraction?**
The answer is yes, especially for Medicare patients. The Office of the Inspector General has determined that ***not*** charging for a provided service is an "inducement" to the patient and therefore illegal: The federal government insists that if a test is preformed, it must be charged for. The government does this because they are worried that some physicians may try to lure patients in to their offices by offering them an incentive such as a reduced fee, and want it to be fair to all doctors and patients who accept Medicare. We are obligated by the government to charge for all of our services.

Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized to your plans benefits when your healthcare insurance company receives and processes the claim.

ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of the refraction and agree to pay for the refraction at the time of service. **Any co-payments due are separate from and not included in the $40.00 fee for the refraction.**

_____ _____
Patient's Signature/ Legal Guardian *Date*

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STATEMENT OF POLICIES

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

- Deductibles and copays are payable at the time of service. **ANY PREVIOUS BALANCE IS EXPECTED TO BE PAID AT TIME OF SERVICE.**
- Patients are responsible for obtaining referrals and authorizations for services rendered.
- If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel or reschedule the appointment. Failure to do so **WILL** incur a $25.00 charge to your account for the missed appointment.
- There is a $25.00 fee for all disability, FMLA and other forms that you need to have filled out by the physician. Please allow 72 hours for these forms to be completed.
- There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc. This charge will be determined by the information requested.

PRESCRIPTION POLICY: If you are in need of a refill, please have your pharmacy fax a request to (904) 354-2122. Please allow 48-72 hours. No refills will be given on Friday after 1:00pm.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND UNDERSTAND THE STATEMENT OF POLICIES, AND AGREE TO ABIDE BY THEM.

Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I have read and understand this medical practice's HIPAA Policy.

- ○ YES
- ○ NO

Name of Patient (PRINT):_____DOB:_____

Signed:_____Date:_____

If not signed by the patient, please indicate relationship:

- ○ Parent or guardian of minor patient
- ○ Guardian or conservator of an incompetent patient
- ○ Beneficiary or personal representative of deceased patient

I give the office of Dr. Adams' & Ransom Agee's permission to discuss my medical condition/treatment with:

- ○ Husband/wife
- ○ Children_____
- ○ Friend _____

AUTHORIZATION FOR RELEASE OF INFORMATION

- ○ ALL past, present and future periods.

OR

Covering the period of health care from:_____to:_____.

_____

FOR OFFICE USE ONLY:

Signed and received by:_____

Reason unable to obtain:_____

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