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11790 San Jose Blvd, Jacksonville, FL 32223 • 2 Shircliff Way, Ste. 120, Jacksonville, FL 32204
1658 St. Vincent's Way, Ste. 250, Middleburg, FL 32068

904.272.2020

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any and all medical records pertaining to my care to:

Clay Eye Physicians & Surgeons

If we are unable to reach you personally, do we have your permission to leave a message on your voice mail or answering machine?

YES NO

When calling our office regarding your care or to request prescription medication, please keep in mind that we need to speak to you directly. This will ensure that both parties receive the correct information.

Also, I give my permission for Clay Eye Physicians & Surgeons to release my medical information to the following people:

Name/Relationship to Patient:

I understand that by signing this form, I have authorized this office to release my medical information.

Patient Name:

Patient Signature:

Date:

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Office Agreement and Consent Form

Payment is due when services are provided. We accept Cash, Check, Visa, Mastercard, Discover, American Express, Care Credit and Alphaeon Credit cards. There is a $45 handling fee for any returned checks.

Medical/Vision Insurance: As a courtesy to you, we will file your claim if we are a Provider for your insurance plan. At the time of your exam, you will be responsible for co-payments, deductibles, co-insurance, a $59 refraction fee (if necessary), and any non-covered charges. After 90 days, any remaining balances will become patient responsibility and billed to you directly. Following the mailing of your second statement, a charge of $15 will be attached to your account for any remaining balances. It is your responsibility to inform us of any changes in your insurance carrier or policy. It is also your responsibility to obtain proper referral/authorization for your visit with us. We may provide some assistance to help obtain the proper authorization. If a referral cannot be obtained for your visit, you will be considered a self pay patient. Self pay patients are responsible for all service fees at time of service.

Our treatment is based on the needs of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company.

After Hours Care: If you should require our services after regular business hours, please understand that there is an additional fee not covered by insurances. This fee of $100 will be billed directly to you.

Collection Fees: If your account becomes delinquent and is submitted to a collection agency, you will be responsible for an additional 37% collection fee. Both the prior balance and the collection fee will need to be paid in full before the practice will see you again.

Refraction: A $59 fee is charged for the performance of the refraction. A refraction is performed to determine your best-corrected vision to distinguish medical eye problems from a simple need for glasses. Most medical insurance plans, including Medicare and Tricare for Life, do not cover routine eye examinations and they do not consider the refraction to be a part of a medical eye exam. When a refraction is performed, our office will collect your refraction charge along with any co-payment and deductible due at the time of service.

I authorize release of any information, records and testing to offices where I have been referred.

Consent: The undersigned hereby authorizes Clay Eye Physicians and Surgeons to perform treatment based on the needs of the patient. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the patient and further authorize and consent that the doctor choose and employ such assistance as deemed fit. I have read and understand the above policy.

Name (printed) Signature Date

Patient's Name (if you are not the patient) Relationship to the Patient Date

Clay Eye
Physicians & Surgeons

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH CARE INFORMATION

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.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us.The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

Who Will Follow The Notice:
The notice describes the practices of our employees and staff as well as any individuals and/or business entities associated with Clay Eye Physicians. In addition, these individuals, entities, sites and locations may share Medical Information with each other for treatment, payment and health care operation purposed described in the notice.

Information Collected About You:
In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- A valid picture ID.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you.Some information may also be provided to us by other individuals or organizations that are part of your “circle of care”---such as the referring physician and your other doctors, your health plan and close friends or family members.

We have available upon your request, a copy of the Federal Guidelines and listing of all types of persons, entities, and/or situations in which we might disclose your personal health care information.

I have received a one-page summary outlining the Privacy rules under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). I acknowledge receipt of this summary as well as the availability upon my request of a copy of the Federal Guidelines.

Patient/Responsible Party Date

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Clay Eye
Physicians & Surgeons

DATE: _____ **MARITAL STATUS:** ☐ M ☐ W ☐ S ☐ D

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____ **AGE:** _____ **SEX:** _____

CITY _____ **STATE:** _____ **ZIP:** _____

CELL #: _____ **HOME #:** _____

SSN #: _____ **WORK #:** _____

MAY WE CONTACT YOU VIA EMAIL: ☐ Y ☐ N **EMAIL:** _____

ARE YOU A VETERAN: ☐ Y ☐ N

PARENT/SPOUSE NAME: _____ **PARENT/SPOUSE DOB:** _____

PARENT/SPOUSE SS #: _____ **WORK PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

PRIMARY INSURANCE NAME: _____ **ID #:** _____

PRIMARY CARD HOLDER NAME: _____ **DOB:** _____ **RELATION:** _____

SECONDARY INSURANCE NAME: _____ **ID #:** _____

SECONDARY CARD HOLDER NAME: _____ **DOB:** _____ **RELATION:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #:** _____

PHARMACY: _____ **PHONE #:** _____

TO BE IN COMPLIANCE WITH FEDERAL GUIDELINES, PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES YOU:

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN
☐ MORE THAN ONE RACE ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ WHITE
☐ OTHER ☐ UNKNOWN/NOT REPORTED

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ NOT REPORTED

PRIMARY LANGUAGE: _____

HOW DID YOU HEAR ABOUT CLAY EYE:

☐ REFERRING PHYSICIAN: ☐ WEBSITE ☐ INSURANCE REFERRAL
☐ HOSPITAL CONSULT ☐ PRINT AD ☐ OTHER _____
☐ ER CONSULT ☐ HEALTH FAIR

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE: 904.272.2020