OFFICE POLICIES

(PLEASE READ CAREFULLY)

GUARANTEE

1. WE GUARANTEE THAT YOUR WILL BE SATISFIED WITH YOUR NEW EYE GLASSES AND/OR CONTACT LENSES; HOWEVER, SHOULD YOU HAVE ANY PROBLEMS, PLEASE BRING IT TO OUR ATTENTION WITHIN 30 DAYS AND ANY CORRECTIONS WILL BE MADE FREE OF CHARGE. CHARGES FOR CHANGES AFTER THE 30 DAYS WILL BE THE RESPONSIBILITY OF THE PATIENT.

PAYMENT

2. FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR OFFICE VISITS. A MINIMUM OF 50% DOWN PAYMENT IS REQUIRED ON THE DAY OF ORDER FOR CONTACT LENSES AND/OR EYE GLASSES. THE BALANCE MUST BE PAID ON OR BEFORE THE DATE OF PICKUP.

PICKUP

3. EYE GLASSES AND CONTACT LENSES WILL BE HELD FOR A MAXIMUM OF THIRTY (30) DAYS UNLESS PRIOR ARRANGEMENTS ARE MADE FOR PICKUP.

FEES

4. CHECKS RETURNED UNPAID WILL BE CHARGED $35.00 SERVICE CHARGE. IF WE DO NOT RECEIVE FULL PAYMENT WITHIN 7 TO 10 BUSINESS DAYS, THE MATTER MAY BE BROUGHT TO DISTRICT COURT. WE RESERVE THE RIGHT TO REQUIRE THAT ALL FUTURE TRANSACTIONS REQUIRE CASH PAYMENT.

5. ALL OVERDUE ACCOUNT MAY BE SENT TO A COLLECTION AGENCY. A COLLECTION FEE OF 25% WILL BE ADDED ON TO COVER COLLECTION EXPENSES.

INSURANCE

6. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, WE WILL BE HAPPY TO COMPLETE YOUR INSURANCE CLAIM FOR OUR SERVICES SO THAT YOU MAY BE REIMBURSED. PLEASE BRING YOUR FORM AT THE TIME OF SERVICE.

7. IF YOUR INSURANCE REQUIRES A REFERRAL, YOU ARE RESPONSIBLE FOR BRINGING IT AT THE TIME OF THE VISIT. IF YOU DO NOT HAVE ONE YOU WILL BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY THE INSURANCE COMPANY.

8. IF WE ARE A PARTICIPANT OF YOUR INSURANCE, WE WILL DEDUCT THE PORTION THAT THE INSURANCE PAYS FROM YOUR BILL AND CHARGE YOU FOR THE DIFFERENCE. IF YOUR INSURANCE COMPANY DENIES A CLAIM FOR NO FAULT OF OUR OWN, YOU WILL BE RESPONSIBLE FOR THE BALANCE DUE. WE WILL BE HAPPY TO RESUBMIT YOUR INSURANCE CLAIM, BUT IF YOUR INSURANCE HAS NOT PAID US AFTER 90 DAYS FROM THE DATE OF YOUR VISIT YOU WILL BE RESPONSIBLE FOR THE BALANCE DUE. OVERDUE ACCOUNTS MAY BE SENT TO A COLLECTION AGENCY AND THE 25% COLLECTION FEE WILL APPLY.

REIMBURSEMENT CHECKS

9. ALL REIMBURSEMENT OR REFUND CHECKS DUE TO PATIENTS WILL BE GENERATED ONCE A MONTH.

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JONES OAKLAND VISION GROUP, P.A.

(The following information is confidential and is imperative for your records)

DATE: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

NAME (LAST, FIRST, MIDDLE): _____ BIRTH DATE: _____ / _____ / _____

P.O. BOX #: _____ APT. #: _____ AGE: _____ SEX: _____M _____F

STREET ADDRESS _____ MARITAL STATUS: ____M ____S ____ Widow/Other

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ARE YOU? _____ EMPLOYED _____ STUDENT _____ RETIRED

CELL PHONE: _____ E-MAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

ADDRESS: _____ OCCUPATION: _____

POLICY HOLDER: _____ PHONE: _____

NAME: DOB:

IN CASE OF EMERGENCY PLEASE LIST A PERSON OUTSIDE YOUR HOME: _____

RELATIONSHIP: _____ PHONE: _____

HOW ARE YOU GOING TO PAY TODAY? _____ CASH _____ CHECK _____ CREDIT CARD

PLEASE THOROUGHLY READ THE BACK OF THIS FORM PRIOR TO SIGNING.

SHOULD YOUR INSURANCE REQUIRE A REFERRAL, IT IS YOUR RESPONSIBILITY TO PROVIDE IT. IF ONE IS NOT PROVIDED, YOU WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR INSURANCE BENEFITS BE MADE ON MY BEHALF TO JONES OAKLAND VISION GROUP, P.A./J.V. JONES O.D. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES TO BE RELEASED. I AUTHORIZE ANY HOLDER OF MEDICARE AND/OR INSURANCE INFORMATION ABOUT ME TO BE RELEASED TO DR. JONES TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I HAVE READ AND AGREE TO THE ABOVE AUTHORIZATION AND THE POLICIES ON THE BACK OF THIS FORM:

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN SIGNATURE _____ DATE _____