

P. Vernon Jones, M.D.  
1550 Riverside Avenue  
Jacksonville, FL 32204  
(904) 355-2654  
(904) 355-7840 Fax

Thank you for making an appointment with our office. We look forward to serving your visual needs. You are scheduled at our **Riverside / Orange Park** office. Enclosed you will find a short vision questionnaire and a patient information form. Please complete these and bring them with you to your appointment. This will give us a brief background on you and your visual history. Please bring any eye medications, as well as a list of all other medications you are taking. Also, bring your current eyewear, including sun wear. **If you are currently a contact lens wearer, you need to wear your contact lenses in for the exam so they may be evaluated. Also, please bring in any contact lens boxes or prescriptions for our records. If you have never worn contacts and are interested in getting contact lenses, you will need a separate contact lens fitting appointment.**

We require a copy of a photo ID (driver's license is okay), because many of our insurance plans require this to insure against fraud. Bring your insurance card and a REFERRAL **if it is required** by your insurance company. If you are unsure if you need a referral, CALL YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL. If you are seen without a referral and the insurance company denies the claim because you did not meet the requirements of your contract, you will be responsible for the TOTAL BALANCE.

**We do not accept Medicaid, Humana Gold, or Avmed.**

Dr. Jones gives a very thorough exam. He will dilate your eyes as part of the examination. Dilation enables him to get a clear and full view of the retina and internal structures of the eye. You should be able to drive after the exam, however, we recommend caution and if you are uncomfortable driving please bring a driver with you.

The complete ophthalmic examination usually takes **ONE AND A HALF TO TWO HOURS**. Please plan accordingly. We try to run as close to schedule as possible, but as with any medical office, there are occasional situations that arise.

Our Jacksonville office is located at 1550 Riverside Avenue, across from Memorial Park. Our Orange Park office is located at 905 Park Avenue, Suite 104, across from Island View Baptist Church. Our office is behind the Eye Center building.

If you have any questions prior to your appointment, please give us a call. Again we look forward to meeting your eye care needs.

Sincerely,

P. Vernon Jones, M.D. & Staff

PATIENT INFORMATION

(Please fill out any Empty areas or correct any mistakes)

Today's Date \_\_\_\_\_ Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Are they a patient of ours now? \_\_\_\_\_

Spouse's Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

IF PATIENT IS A MINOR

Student: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Employer \_\_\_\_\_ Phone: \_\_\_\_\_

PAYMENT INFORMATION

I will take care of my charges by: cash \_\_\_\_\_ check \_\_\_\_\_ credit card \_\_\_\_\_ bill my insurance \_\_\_\_\_

If billing insurance, please provide copy of insurance card to receptionist with photo identification.

INSURANCE COMPANY: \_\_\_\_\_ policy # \_\_\_\_\_

**NAME of Insured:** \_\_\_\_\_ **Insured's date of birth:** \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ policy # \_\_\_\_\_

**IF YOUR INSURANCE COMPANY IS AN HMO OR PPO, ARE YOU REQUIRED TO HAVE A REFERRAL?**

**REFERRAL #** \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_

If someone other than yourself on your insurance company is responsible for payment, please provide the following information about the responsible party:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State and Zip \_\_\_\_\_

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**INSURANCE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Other insurance benefits be made to Dr. Vernon Jones or Precision Optical for services rendered to me. I authorize Dr. Jones to furnish the insurance company with all information required to accurately process any insurance charges incurred. I also understand that all professional services rendered are charged to the patient. Claims will be expedited if Dr. Jones is a provider for my insurance company. However, the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services rendered unless other arrangements have been made. **Charges not paid within 45 days by my insurance company will be billed to me. Kindly notify us within 24 hours if you are unable to keep your appointment. There will be a \$35.00 charge for appointments that have not been cancelled.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Reason for Visit (Please be specific). Some insurance will not pay for routine exams: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Alternate Contact Name & Phone # \_\_\_\_\_

**MEDICAL EYE AND FAMILY HISTORY**

Please check if **YOU** have any of the following. If yes, how long or what type? **CHECK HERE IF NONE** \_\_\_\_\_

Macular Degeneration	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	_____	Blood Disease	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	_____	Cancer or Tumor	<input type="checkbox"/>	_____
Other Eye Problems	<input type="checkbox"/>	_____	Pregnant	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	_____

Does anyone **in your family** have any of the above problems or diseases? If so, who? And which ones? \_\_\_\_\_

Have you ever had any eye surgery? If yes, what type, when and by whom? \_\_\_\_\_

Have you ever had any eye injury? If yes please describe. \_\_\_\_\_

If you wear glasses or contacts, when was your last glasses prescription change? \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_

Name of your Family Physician: \_\_\_\_\_ PHONE: \_\_\_\_\_

**SOCIAL HISTORY**

Any alcohol use? \_\_\_\_\_ If yes, how much? \_\_\_\_\_ Any tobacco use? \_\_\_\_\_ If yes, how much \_\_\_\_\_  
Hobbies: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Married  Single  Divorced  Widowed

**SYSTEMIC REVIEW OF SYMPTOMS**

Check any that apply to you. **CHECK HERE IF NONE** \_\_\_\_\_

Weight loss or gain	<input type="checkbox"/>	Mental Health problems	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>
Loss of Smell	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Painful Joints	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>
Numbness/Headaches	<input type="checkbox"/>	Intestinal Problems	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>

**LIST ALLERGIES TO ANY MEDICATIONS AND YOUR REACTION**

Who may we thank for referring you? \_\_\_\_\_

**LIST YOUR CURRENT MEDICATIONS (Including Aspirin, Blood Thinners, and Eye Medications)**

Name of Medication	Dosage	Times Per Day	Name of Medication	Dosage	Times per Day

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## BILLING POLICY

Our office has trained personnel to assist you with your insurance questions. Dr. Jones is a Medicare participating physician who accepts Medicare assignment. Accepting assignment means that the approved charge, determined by Medicare, is our patient's full charge for the covered services. Medicare pays 80% of this approved charge and the **patient is responsible for the remaining 20% and any non-covered service and deductible**. Some Medicare patients have a secondary policy that will pick up the 20%. We will be happy to bill **ONE** secondary insurance for our patients.

Refractions are the process of determining the eye's refractive error, or need for corrective spectacles and/or contact lens. **It is an essential part of an eye examination** service by Medicare and most insurance companies. Our office fee for refraction is \$30.00 and this fee is collected in addition to any co-payment. **You are asked to pay this amount plus any co-pay due at the time of service.** For your convenience we accept Visa and MasterCard and Discover.

If your insurance company has not paid within **FORTY-FIVE** days, the balance becomes your responsibility. You will also be responsible for all collection fees if your account is turned over to a collection agency.

## ACKNOWLEDGEMENT

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 service. The co-payment is separate from and not included in the refraction fee.

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Patient Signature

Date

## INSURANCE

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We participate in many different insurance plans. If your insurance policy **requires a referral**, please call your primary care doctor and **request a referral at least one week prior to your appointment**. Most insurance plans require that the primary care doctor see you prior to issuing any referrals to see a specialist. We will assist you, but **it is your responsibility** to know your insurance plan and service. Experience has proven that referrals are seldom issued after Dr. Jones has seen you. **SOME INSURANCE PLANS OFFER ONE ROUTINE EXAM EVERY ONE TO TWO YEARS, HOWEVER IF A MEDICAL DIAGNOSIS IS FOUND AT YOUR APPOINTMENT THE INSURANCE COMPANY WILL REQUIRE A REFERRAL. FOR YOUR PROTECTION WE RECOMMEND THAT YOU OBTAIN A REFERRAL. IF YOUR INSURANCE DOES NOT PAY THE BILL BECOMES YOUR RESPONSIBILITY.**

I understand I will be responsible for any non-covered charges incurred because I did not obtain a referral or meet other requirements by my insurance company.

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Patient Signature

Date

## WHO'S WHO IN EYE AND VISION CARE?

“An ophthalmologist is a doctor of medicine or osteopathy (M.D. or D.O.). Such a physician is licensed to practice medicine and surgery, and specializes in all aspects of eye and vision care. The specialist’s education typically includes four years of college, four years of medical school, one or more years of general hospital experience in treating diseases and three or more years in hospital-based eye residency program. In diagnosis and treatment, the ophthalmologist uses and prescribes medicines, glasses, contact lenses, and performs surgery.”

“An Optometrist is a doctor of optometry (O.D.). Such a professional is licensed to practice optometry and specializes in determining the need for glasses and screens the patient for abnormalities of the eye. The optometric education consists of 2-4 years of college and 4 years in an optometric college. The optometrist treats visual disturbances with glasses and contact lenses and may also prescribe exercises for muscle imbalances.”

“An optician is licensed to fit, adjust, and dispense glasses and other optical devices on the written prescription of a licensed physician or optometrist.”

### EYE HEALTH CHART

#### Signs or Symptoms Suggesting the Need for Medical Eye Care

If you have any of the symptoms listed below, contact your ophthalmologist.

- Blurry vision uncorrectable by lenses
- Double vision
- Dimming of vision that comes and goes, or sudden loss of vision
- Red Eye
- Eye pain
- Loss of side vision
- Halos (colored rays or circles around lights)
- Crossed, turned, or wandering eye
- Twitching or shaking eye
- Flashes or streaks of light
- New floaters (spots, strings, or shadows)
- Discharge, crusting, or excessive tearing
- Swelling of any part of the eye
- Bulging of one or both eyes
- Difference in the size of the eyes

PLEASE RECORD ANY QUESTIONS YOU WANT TO MAKE SURE AND HAVE ANSWERED AND BRING WITH YOU.

Questions for Dr. Jones

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

**ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_