Jackson Eye Care

www.jacksoneyecare.com

Tel. 862-904-8349
Fax 862-203-2197

Kurt T. Jackson, MD

22 Old Short Hills Road, Suite 202
Livingston, NJ 07039

TODAY'S DATE _____ **DIABETIC?** YES_____NO_____

PREFERRED LANGUAGE_____ **ALLERGIES?** YES_____NO_____

			♂ MALE ♀ FEMALE	( )
LAST NAME / APELLIDO	**FIRST NAME** / NOMBRE	M.I.	**GENDER**/GENER(	**HOME PHONE**/TELEFONO DE CASA
D.O.B / FECHA DE NACIMIENTO	**SOCIAL SECURITY** #/ NUMERO DE SEGURO SOCIAL			**CELL PHONE**/TELEFONO CELULAR ( )

ADDRESS/DIRECCION	APT#	**CITY**/CIUDAD	**STATE**/ESTADO	ZIP CODE

PARENT/GUARDIAN'S FULL NAME-NOMBRE DE MADRE O PADRE

EMAIL ADDRESS/ CORREO ELECTRONICO

MARITAL STATUS / ESTADO CIVIL

MARRIED SINGLE DIVORCE WIDOW

RACE:

AMERICAN INDIAN/ALASKA NATIVE
ASIAN
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
WHITE
BLACK OR AFRICAN AMERICAN

ETHNICITY:

NON HISPANIC OR LATINO
HISPANIC OR LATINO

REFERRING PHYSICIAN / DOCTOR REFERIDO **PHYSICIAN'S PHONE**/TELEFONO DEL DOCTOR **LAST VISIT**/ULTIMA VISITA

PHARMACY NAME & PHONE# - FARMACIA & TELEFONO **PRIMARY DOCTOR & PHONE#**/ DOCTOR PRIMARIO & Telefono

EMPLOYMENT INFORMATION / INFORMACION DE TRABAJO

COMPANY NAME | CITY/STATE | OCCUPATION | WORK PHONE NUMBER

EMERGENCY CONTACT INFORMATION

CONTACT NAME	PHONE #	RELATION
1		
2		

EYE PROBLEM BRINGING YOU TO OUR OFFICE _____

PROBLEMA EN EL OJO QUE LO TRAE A LA OFICINA

PLEASE CHECK: **RIGHT/** DERECHO **LEFT**/ IZQUIERDO BOTH

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE PAYMENTS, HOWEVER, THE PATIENT IS RESPOSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE **DR. KURT JACKSON** TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR FOR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT I RECEIVED MY **HIPAA PRIVACY PRACTICES NOTICE**.

PATIENTS WHO HAVE MEDICARE SHOULD BE AWARE THAT CERTAIN SERVICES ARE NOT COVERED BY MEDICARE AND THE PATIENT IS RESPONSIBLE FOR THEIR PAYMENT.

TODAY'S DATE **PATIENT'S SIGNATURE** --- PARENT'S SIGNATURE (**ALSO PRINT NAME**)

REVISED 04-2022

MEDICAL HISTORY AND REVIEW OF SYSTEM

Patient's name _____ Age_____Weight _____Height_____

CIRCLE MEDICAL CONDITION:

If you have **no** medical condition circle: **NONE**

VACCINES: **FLU** shot date _____ **PNEUMONIA** shot date_____

COVID -19 Yes No - Pfizer Moderna J&J Dates_____, _____, _____

CARDIAC: PACEMAKER A-FIB
NONE HIGH CHOLESTEROL STENT(S)
CVA (STROKE) HYPERTENSION
OTHER_____

RESP: ASTHMA BRONCHITI EMPHYSEMA
NONE SLEEP APNEA COPD
*COVID 19 -Dx.

ENDO: OBESITY OSTEOPOROSIS
NONE DIABETES GOUT THYROID (Hypo or Hyper)
* Dx. date_____ *** HBA1C_____**
BLOOD SUGAR _____FASTING: Y___ N___

BLOOD: ANEMIA LEUKEMIA
NONE AIDS - HIV HEPATITIS
BLEEDING PROBLEM

RENAL: PROSTATE DIALYSIS KIDNEY DISEASE
NONE HEPATITIS JAUNDICE

GASTRIC: ULCER REFLUX GASTRITIS
NONE _____

EENT: CATARACTS
NONE GLAUCOMA
BLURRED VISION
VERTIGO HEARING AIDS
OTHER_____

SKIN: DERMATITIS ECZEMA
NONE PSORIASIS

NEURO: SEIZURE EPILEPSY
NONE ALZHEIMER'S PARKINSON'S
MIGRANES PARALYSIS
AUTISM ADHD
OTHER_____

SKELETAL: ARTHRITIS LUPUS
NONE

PATIENT'S CANCER: YES_____NO_____
HISTORY:_____

ALLERGIES:

DRUGS:_____
FOODS:_____
OTHER:_____

PAST SURGICAL HISTORY

MEDICATIONS:

SOCIAL HISTORY:

ALCOHOL: NONE_____SOCIALLY_____

SMOKING: YES___ NO___ STOPPED ___WHEN?_____
HOW MUCH DO YOU SMOKE?_____

DRIVING: YES___ NO___

FAMILY HISTORY:

PARENTS: FATHER: DIABETES HIGH BLOOD PRESSURE
CANCER HEART DISEASE

MOTHER: DIABETES HIGH BLOOD PRESSURE
CANCER HEART DISEASE

Jackson Eye Care

HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Jackson Eye Care, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Jackson Eye Care, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Jackson Eye Care, LLC has already made in reliance prior to my consent. Jackson Eye Care, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Protected Health Information Release Form

Patient Name: _____ Date of Birth: _____

I acknowledge that Jackson Eye Care, LLC has provided me with a copy of their Privacy Notice.

Signature: _____ Date: _____

I hereby authorize the following individual(s) full / partial disclosure of my medical records including: Diagnosis, Treatments, Billing Issues, Appointment Information and Prescriptions, in accordance with HIPAA regulations.

*Concerning matters of my health, I give permission to speak with:

Name of Person(s): _____ Relationship to Patient: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

***It is my responsibility to notify the office in writing if I no longer wish the individual listed to have access to my records, or any other change to availability of my information.**

Jackson Eye Care

Patient agreement of Office Policies

1. Please confirm at the front desk **ON EVERY VISIT** change in the following:
    a. Address
    b. Phone Numbers (Home / Cell / Work Number)
    c. Insurance
    d. If currently residing in a Skilled Nursing Facility

2. It is important that you notify the front staff if you are currently residing in (or were recently discharged from) a Skilled Nursing Facility prior to treatment to receive written confirmation.

3. In order to expedite your time in the office, please come prepared with your referral (if required) and pay all payments prior to being seen. Payments may consist of co-pays, deductibles and co-insurance payments depending on your insurance coverage.

4. Please be aware that insurance companies authorize referral visits two ways:
    a. They issue a number of visits.
    b. They issue a time frame. If visits are not utilized within the time frame you are given, the visits will expire and you're responsible to know how many visits you have and when the time frame is up.

5. We will utilize your insurance based upon your policy provisions. However, the ultimate responsibility rests on the patient.

6. Any and all diagnostic testing should **NEVER** be missed. Test results are vital to your doctor's ability to determine the appropriate treatment plan for you.

Patient Name:_____

Signature: _____ Date: _____

Jackson Eye Care

Jackson Eye Care, LLC Financial Policies

Patient Name: _____ Date of Birth: _____

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage and assign to Jackson Eye Care, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize Jackson Eye Care, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

Signature: _____ Date: _____

Cancellation Policy: I, the undersigned, understand that as a patient at Jackson Eye Care, LLC I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a $25 cancellation fee.

Signature: _____ Date: _____

Medicare Patients: If you are covered by Medicare, please read and sign the following: In Medicare cases, Jackson Eye Care, LLC agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of Medicare.

Co-Payments and Co-Insurance: Co-payments and co-insurance must be paid at each visit according to your insurance contract. **Patients with GHI and Empire coverage are also responsible for diagnostic co-pays.** We do perform diagnostic tests and co-pays will be collected at time of check out. Please plan accordingly. We accept cash, check, and credit cards (Visa, Master Card, American Express, or Discover).

Worker' Compensation Only: You may become responsible for medical costs of treatment for your illness or condition with Dr. Jackson if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a cause of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and an approved pursuant to Workers' Compensation #32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

Patient/Guardian Signature: _____ Date: _____