

1190 N. STATE ST., STE 403 JACKSON, MS 39202
401 BAPTIST DR., STE 408 MADISON, MS 39110
102 CLINTON PKWY, 3RD FLR CLINTON, MS 39056



TELEPHONE: 601-353-2020 / FAX 601-352-5988
TELEPHONE: 601-853-2020 / FAX 601-853-2728
TELEPHONE: 601-924-9750 / FAX 601-925-9791

PATIENT'S INFORMATION:

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____ SSN: _____

Date of Birth: _____ Age: _____ Gender: Male or Female Marital Status: Married/Widowed/Single/Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work phone: () _____ EXT: _____

Email Address: _____ Would you like to receive news about JEA through email? Y or N

Cell Phone: () _____ Additional Phone #?: _____ (Who's # or Type) _____

Patient's Employer: _____ Address: _____

Spouse's Name: _____ Spouse's SSN: _____

Spouse's Date of Birth: _____ Spouse's Employer and Address: _____

Spouse's Work Phone: () _____ EXT: _____ Spouse's Cell phone: () _____

REFERRED BY (PLEASE PICK ONE):

Dr: _____ / Patient: _____

Hospital Referral Line / Yellow pages / Radio / Newspaper / Website / Health Fair / Business Expo / Other: _____

CONTACT PERSON : (IF UNABLE TO REACH PATIENT) SOMEONE NOT LIVING WITH YOU.

Name: _____ Relationship: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____ EXT: _____

IF PATIENT IS A MINOR: (FILL OUT)

Mother's Last Name: _____ Mother's First Name: _____ MI _____

SSN: _____ Date of Birth : _____

Employer: _____ Work Phone: () _____ EXT: _____

Home Address (If different from above: _____ Cell Phone: () _____

Father's Last Name: _____ Father's First Name: _____ MI _____

SSN: _____ Date of Birth : _____

Employer: _____ Work Phone: () _____ EXT: _____

Home Address (If different from above: _____ Cell Phone: () _____

JACKSON EYE ASSOCIATES PLLC

Primary Insurance: _____ Owner Name: _____

Secondary Insurance: _____ Owner Name: _____

Third Insurance: _____ Owner Name: _____

FINANCIAL POLICY

Payment Due: I understand that payment is due when service is rendered.

Co-pays, Co-insurance and Deductibles. It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.

Billing Fee: If for some reason I am not able to pay at the time of service, my appointment may be rescheduled. A \$15.00 billing fee will be added.

Insurance Coverage: I acknowledge that the insurance cards I have presented are current and accurate.

Non-covered Services: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.

Denied Charges: I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carrier deems them payable or not and that I am obligated to pay for these services in full.

Refractions: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lens. Medicare and most medical insurances do not cover the fee for refractions. I understand that I am responsible for this **\$25.00 fee** and it is payable at the time of service.

Participating Insurance Plans: If JEA is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at that time of service

Returned Checks & Past Due Accounts: Return checks will be subject to collection charges, penalties and interest. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in being turned over to an outside collection agency and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full.

Medicaid, I understand that if Medicaid is my secondary coverage and that if my primary insurance has a co-pay, I will be responsible for paying my co-pay amount associated with my primary insurance plan. JEA will not file a claim with Medicaid because Medicaid does not cover co-pays. If I have exceeded my yearly allotted visits with Medicaid, I will be responsible for paying for my visit in full at the time of service. If Medicaid is my only carrier, I am responsible for paying the Medicaid co-pay amount at the time of service.

CHIPS (Children’s Health Plan) I understand that JEA participates in the CHIP program for medical conditions only. JEA Physicians do not participate in CHIPS vision plan. If no medical diagnosis is found, even if you were referred by another physician, you will be responsible for all charges.

Vision Plans: JEA participates in a very limited number of vision plans. It is your responsibility to know which plans are accepted and which physician participates in the plan.

I have read the JEA Financial Policy and understand, that I, the patient or the patient’s representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Jackson Eye Associates, PLLC.

Signature of the Patient or Patient Representative