Valley Eye & Laser Center / Valley Optical
Jonathan D. Jahnke, MD
Ophthalmologist, Physician and Surgeon

Name_____
First Middle Last

Sex: Male / Female Date of Birth: _____/_____/_____/ Age:_____

Mailing Address: _____

City, State, Zip :_____

E-mail Address: _____

Social Security #: _____-_____-_____ Marital Status: Married Single Widowed Divorced

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Occupation: _____ Employer:_____

Emergency Contact: _____ Phone ( ) _____-_____

Relationship to Patient: _____

Primary Care Physician: _____ Phone ( ) _____-_____

Referring Physician: _____ Phone ( ) _____-_____

_____ _____
Sign (legal guardian must sign if a patient is a minor) **Date**

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Patient Name: _____ Date of Birth: _____

Please List ALL Prescription Medications

Medication	**Dose**	**Times per day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies
(please only list allergies to medications)

_____

_____

_____

_____

_____

Valley Eye Center
Jonathan D.Jahnke, MD
Valley Optical

Patient Acknowledgement and Signature Form

FINANCIAL POLICY

Initials _____

Valley Eye Center (Jonathan Jahnke, MD and Valley Optical) values the confidence you have shown in choosing him as your eye health care provider. You should be aware of what services your insurance may or may not cover. As a courtesy, Valley Eye Center will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill, including deductibles, co-payment/co-insurance and non-covered services, as determined by your contract with your insurance carrier. Valid insurance cards must be presented at the time of service. Co-pays will be collected at the time of service. Valley Eye Center will require payment in full for non-covered procedures, services and products at the time of service (or at a pre-operative appointment). If your insurance requires a referral, is the responsibility of the patient to secure that referral prior to receiving services or products from Valley Eye Center.

You will receive a statement showing activity and balances due on your account. Valley Eye Center accepts cash, checks, MasterCard and Visa. Any remaining balance owed by you, after insurance has paid, is due in full when you receive your first bill. A$35 bank fee will be charged for non-sufficient funds checks. Balances not paid within 30 days will be subject to finance charges. Separate billings may be received for laboratory, anesthesiology, radiology, hospital services surgical assistant providers who are involved in your care and are subject to their financial policies.

SELF PAY PATIENTS

Initials_____

Valley Eye Center patients without insurance are required to pay in full at the time of service. Self pay patients may be offered a discount on office visits.

PRESCRIPTION AGREEMENT

Initials_____

I understand that I am to contact my pharmacy directly for prescription refills. I will allow at least 3 business days for my Rx to be authorized by Dr. Jahnke. I understand that Dr. Jahnke will **NOT authorize** prescription refills outside of office hours, Monday through Friday or on weekends. Failure to keep scheduled appointments and unapproved use of medication may result in the termination of prescription refills. Loss, theft, or other mishaps rendering my medication unusable will not be reason to refill medication early. I undeerstand it is my responsibility to plan accordingly to ensure that I do not run out of prescribed medication.

NOTICE OF PRIVACY PRACTICES- ACKNOWLEDGEMENT AND CONSENT

I understand that Valley Eye Center will use and disclose health information about me. I understand that my health may include information both created and received by the practice, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that Valley Eye Center may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Valley Eye Center will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Valley Eye Center, and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revision. I also understand that a copy of the most current version of the Notice of Privacy' Practices is available at the office. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Valley Eye Center is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

BENEFIT ASSIGNMENT

I, and/or my dependent(s), assign directly to Valley Eye Center all insurance benefits, if any, otherwise payable to me for products or services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Valley Eye Center may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining benefits.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE

By signing below, I acknowledge that I have read and understand all information included in this policy and allow Valley Eye Center to download any historical pharmaceutical history.

_____ _____ _____

Patient/Patient Representative Signature | Relationship (if not patient) | Date