JOHNSON i-CARE

Medication Form

Patient's Name: Last	First	**Date of Birth**	**Today's Date**

Please List All Current Medications, Vitamins or Supplements. If you have a list on hand, we're happy to make a copy. If you are unsure of the name of the Medication, list the type and condition for which you're taking that Medication.

Name of Medication or Supplements	Reason for Use	Currently In Use	Recently Discontinued	Reason for Termination

Signature of Patient or Guardian	**Print Name**	**Date Reviewed**	**Doctor's Signature**

Turn Page

JOHNSON i-CARE

Financial and Privacy Policies

Insurance Authorization and Assignment. I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Johnson i-Care, PLLC for provided services. I authorize Johnson I-Care to release necessary medical or other information about me to my private insurance company, Medicare and Medicaid or other company, and its agents, which might provide coverage to me.

All Payments are the Responsibility of the Patient. Johnson I-Care will gladly bill my insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed with insurance. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary care physician, and I do not furnish the correct referral at the same time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due.

Co-pays, Deductibles and Payments are Due at Time of Service. I understand that not all services and materials may be covered by my insurance, or they may exceed my benefits or coverage. I agree to pay all co-pays, deductibles and payments at time of service for all services and materials.

Treatment of Minors: a parent or legal guardian must acknowledge our policies and hereby provide his/her consent on behalf of the minor patient prior to any services performed by any staff member of Johnson i-Care.

Acknowledgement of Privacy Practices Policy (HIPAA): I understand that in an effort to protect the privacy of my health information, Johnson i-Care has established a HIPAA compliant privacy policy. This policy details the use and/or disclosure of information contained in my personal optometric/medical records kept for the purposes of diagnosis and treatment of my eye health, and payments for services performed. In accordance with HIPAA Regulations, a copy of the Johnson i-Care Privacy Policy was presented to me in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

_____ I have read and accept the Financial and Privacy Policies of Johnson i-Care, PLLC

Emergency Contact: _____ _____ _____

Name Relationship Phone

_____ _____ _____

Patient's Name [print] **Signature of Patient or Guardian** **Date**