



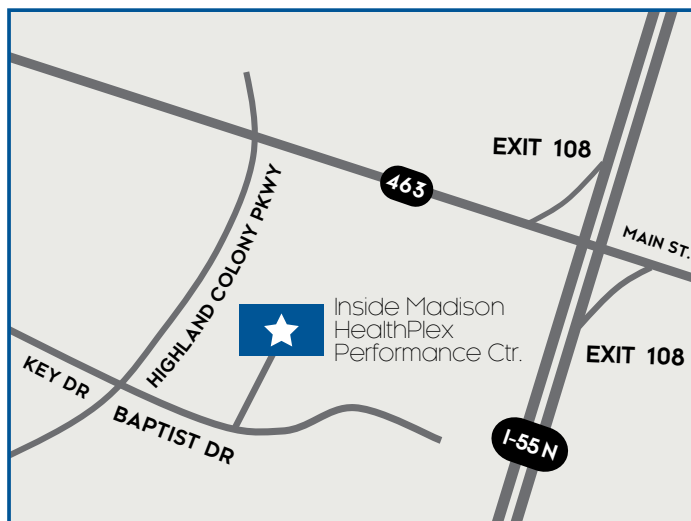
It's as easy as 1 - 2 - 3!

1 - Complete all of the forms in section 1.

2 - Sign these release forms regarding your information.

3 - This section is for surgery patients only, but contains important information!

We can't wait to see you...and help you get a new look at life.



INSIDE MADISON HEALTHPLEX PERFORMANCE CENTER

Coming from Jackson:

Take the Madison, Hwy 463 Exit (Exit 108)

Go left (west) and go across I-55

Turn left at Highland Colony Parkway. This will be at the 2nd red light.

Take the 1st left onto Baptist Drive.

We are the 2nd building, Suite 220 in the Madison HealthPlex Performance Center.

SURGERY CENTER

When you find out that you need eye surgery, you'll most likely experience feelings of nervousness and concern. That's perfectly normal. We understand how patients feel—mostly because vision is such an important part of everyday life!

We've been performing difficult and precise eye procedures for decades. In some cases, Dr. Ashford has been the first to perform certain specialty eye surgeries in the Jackson area. Our doctors have over 50 years of combined experience, giving them the confidence and expertise to provide the care you need. So there's no need to worry...we'll help you stop worrying about your vision and get back to living your life.

Our office has the only single-specialty ophthalmic surgery center in the city of Madison. We have state-of-the-art operating rooms and the very latest surgical technology.



STEP 1 • PATIENT INFORMATION

Date _____ **Please complete the FRONT AND BACK of each page**
Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Phone: Home (____) _____ Work (____) _____ Cell (____) _____
SS# _____ Date of Birth _____ Age _____
E-Mail Address _____ Gender Male Female

Marital Status Married Single Widowed Divorced Separated

Ethnicity Hispanic/Latino Not Hispanic/Latino

Preferred Language English Spanish Other _____

Race White Black/African American Asian American Indian/Alaska Native

Native Hawaiian/Pacific Islander Other _____

Employer _____ Occupation _____

Employer Address _____

Spouse's Name _____ Date of Birth _____ SS# _____

Spouse's Employer _____ Work (____) _____ Cell (____) _____

Emergency Contact Person _____ Phone (____) _____

Referred By TV Radio Yellow Page Insurance Website Brochure Self Magazine
 Family Friend Patient Physician (Name of Friend, Patient, or Physician: _____)

Preferred Communication Method Mail Phone Text Message Email

(Eye Group will primarily use your preferred method of communication but may occasionally use texting and other methods you provide.)

Please Complete If Patient is Under 18 Years of Age

Mother's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Mother's Employer _____ Work (____) _____ Cell (____) _____

Address (If Different from Above) _____

Father's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Father's Employer _____ Work (____) _____ Cell (____) _____

Address (If Different from Above) _____

STEP 1 • PATIENT INFORMATION

Preferred Pharmacy Information

Pharmacy Name _____ Pharmacy Phone _____
Address _____ City _____ State _____ Zip _____

Primary Insurance _____ Policy # _____
Address _____ Group # _____

NOTE: IF THE POLICY IS IN THE NAME OTHER THAN PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION:

Subscriber/Owner _____ Relation to Patient _____
SS# _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Policy # _____
Address _____ Group # _____
Subscriber/Owner _____ Relation to Patient _____
SS# _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____

PLEASE READ AND SIGN THE STATEMENTS BELOW

I request that assignment of my healthcare insurance benefits be made to Drs. Elizabeth Wyatt Mitchell and/or William Ashford, and/or Kevin Kosek and/or Eye Surgery and Laser Center, LLC for any services furnished to me. I authorize the release of any medical information necessary to process these claims.

In order to decide if glasses are necessary and to get the correct prescription you must be refracted. Medical insurance plans will not cover this. You will be responsible for this fee on the date of service. I understand and agree with the above information.

Patient or Responsible Party Signature _____ **Date** _____

I understand that I, the patient or patient representative, are responsible for payments of charges for services rendered. A service charge of 1-1/2% plus collection fees may be added to any outstanding balance due from patient. I give my consent to receive communications from servicers and collectors of my accounts, through 1) cell, landline, or text numbers that I provide, 2) email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Patient or Responsible Party Signature _____ **Date** _____

I understand that it is my responsibility to check with my insurance company to verify that the Eye Group physicians are in my insurance network.

Patient or Responsible Party Signature _____ **Date** _____



STEP 1 • PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Date _____

RECORD OF MEDICAL CARE PATIENT HISTORY QUESTIONNAIRE

PAST HISTORY

INSTRUCTIONS: Please answer the following questions about your medical status and history.

Birth Date: ____/____/____ Last Medical Exam: ____/____/____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Medical Doctor's Phone (____) _____

Do you have allergies to medications: Yes No

If yes, please list: _____

List any Medications you take (Including oral contraceptives, aspirin, eye drops, over the counter medications and home remedies. Include mg. and dosage, attach additional sheet if necessary.): None Yes _____

List any medical conditions (i.e., high blood pressure, diabetes, etc.) that you have had in the past or are currently experiencing. _____

Have you ever taken Flomax or generic Flomax (Tamsulosin, Rapiflo)? Yes No

Do you currently wear Contact Lenses? Yes No Have you ever worn Contact Lenses? Yes No

If yes, please list Brand and Strength/power _____

List all major injuries, surgeries, heart attacks, strokes, and/or hospitalizations you have had:
(Include EYE Surgery, Laser, Injury) None Yes _____

Mark any of the following that you have / had: None Crossed eyes Lazy eye Drooping eyelid
 Glaucoma Prominent eyes Retinal disease or detachment Cataracts Eye infection
 Eye injury Other _____

STEP 1 • PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS

**INSTRUCTIONS: Do you currently or have you ever had any problems in the following areas:
(IF YES, please explain and list medications).**

Neurologic

Explain

Headaches [] Yes _____ [] No
Seizures [] Yes _____ [] No

Neurologic

Explain

Migraine [] Yes _____ [] No
Ocular migraine [] Yes _____ [] No

Eyes

Explain

Loss of vision [] Yes _____ [] No
Distorted vision [] Yes _____ [] No
Loss of side vision [] Yes _____ [] No
Double vision [] Yes _____ [] No
Dryness [] Yes _____ [] No
Itching [] Yes _____ [] No
Foreign body [] Yes _____ [] No
Eye pain/soreness [] Yes _____ [] No
Seeing flashes [] Yes _____ [] No
Chronic Infections [] Yes _____ [] No

Eyes

Explain

Blurred vision [] Yes _____ [] No
Halos/glare [] Yes _____ [] No
Loss of central [] Yes _____ [] No
Mucous discharge [] Yes _____ [] No
Sandy/gritty [] Yes _____ [] No
Burning [] Yes _____ [] No
Excess tearing [] Yes _____ [] No
Redness [] Yes _____ [] No
Tired eyes [] Yes _____ [] No
Stye/Chalazion [] Yes _____ [] No

Ear, Nose, Mouth & Throat

Explain

Allergies [] Yes _____ [] No
Sinus Congestion [] Yes _____ [] No
Post-nasal drip [] Yes _____ [] No
Dry throat/mouth [] Yes _____ [] No
Hay fever [] Yes _____ [] No
Runny Nose [] Yes _____ [] No
Chronic cough [] Yes _____ [] No

Gastrointestinal

Explain

Diarrhea [] Yes _____ [] No
Constipation [] Yes _____ [] No

Bones/Joints/Muscles

Explain

Rheumatoid Arthritis [] Yes _____ [] No
Joint pain [] Yes _____ [] No
Muscle pain [] Yes _____ [] No

Respiratory

Explain

Asthma [] Yes _____ [] No
Emphysema [] Yes _____ [] No
Chronic Bronchitis [] Yes _____ [] No

Lymphatic/Hematologic

Explain

Anemia [] Yes _____ [] No
Bleeding [] Yes _____ [] No

Cardiovascular

Explain

High blood pressure [] Yes _____ [] No
Heart pain [] Yes _____ [] No
Vascular disease [] Yes _____ [] No

Endocrine

Explain

Thyroid/other glands [] Yes _____ [] No
Diabetes [] Yes _____ [] No
High Cholesterol [] Yes _____ [] No

STEP 1 • PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS (continued)

INSTRUCTIONS: Do you currently or have you ever had any problems in the following areas:
(IF YES, please explain and list medications).

Psychiatric

Explain

Depression [] Yes _____ [] No
ADD/ADHD [] Yes _____ [] No

Psychiatric

Explain

Anxiety [] Yes _____ [] No
Dementia/Alzheimer's [] Yes _____ [] No

FAMILY HISTORY

INSTRUCTIONS: Please note any FAMILY history (parents, grandparents, siblings, and/or children – living or deceased) of the following medical conditions:

Relation

Blindness [] Yes _____ [] No
Cross eyes [] Yes _____ [] No
Macular degeneration [] Yes _____ [] No
Cataract [] Yes _____ [] No
Glaucoma [] Yes _____ [] No
High blood pressure [] Yes _____ [] No
Arthritis [] Yes _____ [] No
Other Retinal Detachment [] Yes _____ [] No

Relation

Lupus [] Yes _____ [] No
Cancer [] Yes _____ [] No
Heart disease [] Yes _____ [] No
Kidney disease [] Yes _____ [] No
Thyroid disease [] Yes _____ [] No
Diabetes [] Yes _____ [] No
Other [] Yes _____ [] No

SOCIAL HISTORY

INSTRUCTIONS: Please answer the following questions related to your social history:

Current

Tobacco: [] Every day [] Some days [] Former [] Never
Alcohol: [] Every day [] Some days [] Former [] Never
Illegal drugs: [] Every day [] Some days [] Former [] Never
Infection/exposure: [] Every day [] Some days [] Former [] Never

Please complete the FRONT AND BACK of each page

IMPORTANT MEDICAL/VISION INSURANCE INFORMATION

Thank you for choosing to trust Eye Group with your eye care. Our goal is to provide the best care and patient experience available. The information below is provided in an effort to help clarify the role of vision insurance and medical insurance in your care at our office.

Initial

Many of our patients have both Vision and Medical Insurance. It is the policy of our office to file with only one type of insurance at each visit, either Vision or Medical. The determination of which insurance is filed is based on the diagnosis made by your physician. If your visit results in a medical diagnosis, only your medical insurance will be filed. In this case, if you would like to file a claim against your vision plan, please request a copy of your superbill upon checkout.

Initial

We will file Vision Plans only when your physician determines your visit to be a normal/routine exam (example glasses or contacts) and no medical diagnosis is present. If a medical diagnosis is found (example dry eye, cataract, etc.) your Medical Insurance will be filed. Upon checkout we will know if you have a medical diagnosis and your Medical Insurance will be filed or if your exam was routine only and your Vision Insurance will be filed.

Initial

Because there is great variability in the benefits among individual Vision Plans and Medical Insurance, it is not possible for us to determine on the date of service the exact amount you will owe to the doctor for the exam, refraction, the contact lens fitting process, and/or contact lens supply. Please understand there is a possibility you will be billed further for any amount your insurance plan deems non-covered. The amount you may have paid in the office is an estimate only.

Initial

*If you do not have a medical diagnosis, and the exam, refraction, the contact lens fitting process, and/or contact lens supply can be filed on your Vision Plan, the contact lens fitting fee is to be paid up front by you, the patient. You will be refunded for the contact fitting fee 7 – 10 days after our office receives payment from your vision plan. ***Please see the Contact Lens Policy****

We hope this information is helpful in explaining the role of Vision and Medical Insurance. We also have a dedicated billing staff that is available to assist you at any time at your request. We thank you again for choosing us to be your eye care provider.

Patient or Responsible Party Signature _____ Date _____

AUTHORIZED RELEASE OF PERSONAL MEDICAL INFORMATION

Please list family member/others who may need to speak with any of our staff regarding, but not limited to, your medical information such as:

- Coordination of Care
- Billing / Insurance
- Scheduling

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Please list any Specific Instructions or Limitations:

This authorization will remain in effect unless request is received by our office in writing.

By signing this form, I authorize the release of my personal medical information to above persons.

Patient or Responsible Party Signature _____ **Date** _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgement. Please review on our website at www.EyeGroupms.com.

A copy of our **Patient Rights and Responsibilities** will be provided to you at your first visit. It explains your rights as a patient in the event that an in office or surgical procedure is to be performed. If you would like to review prior to your appointment, you may do so on our website at www.EyeGroupms.com.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from:

Privacy Officer
Eye Group
501 Baptist Drive, Suite 220
Madison, MS 39110

By signing this form, you acknowledge that you have reviewed our **Notice of Privacy Practices** and our **Patient Rights and Responsibilities**, and have no further questions regarding these forms.

Patient or Responsible Party Signature _____ **Date** _____

STEP 2 • RELEASE FORMS

Please read each statement and initial documenting that you reviewed and understand the policies.

Breach of Security Statement

_____ Initial In the event of a security breach or other system wide correspondence that requires my notification, I authorize you to contact me by the email address I provided to you.

I understand that:

- If I do not have access to email, that I will be informed by phone or mail;
- That I am responsible for giving you any updates of my email address; and that Eye Group will not be held responsible if they are unable to contact me if I have not done so.

Fee for Release of Records

_____ Initial I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

Fee for Completion of Forms

_____ Initial I understand that there may be a charge for the completion of forms such as, but not limited to, FMLA, appeals, physicals, workman's compensation, etc.

Fee for Same Day Work-In

_____ Initial If I have a medical problem and seen as a same day work in patient, I may be charged CPT Code 99058. This charge may not be paid for by my insurance company.

Patient Communication

_____ Initial I understand the Eye Group and/or The Eye Surgery and Laser Center, LLC may use phone texts to contact me for appointments, upcoming events, or educational purposes. If I receive a text, I will have the ability to opt out of future texts at that time.

Patient or Responsible Party Signature _____ Date _____

Printed Name _____

1. Nothing to eat or drink after: **MIDNIGHT** (EXCEPT for medication as outlined in Item #3)
2. Bring a list of current medications (this includes: vitamins, supplements, and pain relievers) AND surgeries.
3. On the morning of surgery take all of your scheduled medication **as early as possible** with a small sip of water. **IF YOU ARE A DIABETIC: Speak with a surgery center nurse about taking your medication.**
4. So that surgery will not be delayed, you **MUST** have a driver to and from your surgery. Your driver **MUST** stay at the surgery center at all times. Due to limited seating space bring only your driver with you on surgery day.
5. Wear comfortable clothing on the day of your surgery. You will not have to change your clothes.
6. **DO NOT** wear makeup. Leave jewelry and other valuables at home.
7. You will receive separate bills from your physician, the surgery center, and the anesthesiologist.
8. There is a kit fee for supplies including cataract sunglasses, a plastic shield, and tape. PLEASE RETAIN THIS KIT and remaining supplies if you will have surgery on your SECOND EYE. Please ask our Patient Representative or Nursing staff if you have questions.
9. Remove hearing aids prior to surgery.
10. Remove soft or hard contacts 2 days prior to surgery.
11. To reschedule or for additional questions call surgery center staff at 601-985-9120.
12. **The surgery center staff will be in contact with you if you need to start drops (1 day prior to surgery). You may be asked to administer 3 different drops (if your insurance does not cover the medication listed, please let our office know).**
13. **If applicable, start drops 1 day prior to surgery.** Use your drops when you wake up on the day of surgery. Continue the drops after surgery, do not rub the eye, and wear the shield when asleep or napping. (Unless directed by your physician otherwise.)
 - a) **Prolensa:** 1 drop 1 time a day in both eyes. Wait 5 minutes between each type of drop.
 - b) **Lotemax:** 1 drop 4 times a day (breakfast, lunch, dinner, and bedtime) in both eyes. Wait 5 minutes between each type of drop.
 - c) **Besivance:** 1 drop 4 times a day (breakfast, lunch, dinner, and bedtime) in both eyes. Wait 5 minutes between each type of drop. This drop is thicker; please use last when administering drops.

FOR SECOND EYE SURGERY: Contact your pharmacy if you need a refill on your drops.

Bring your kit and drops with you to the post-op appointment you will have the morning after surgery.

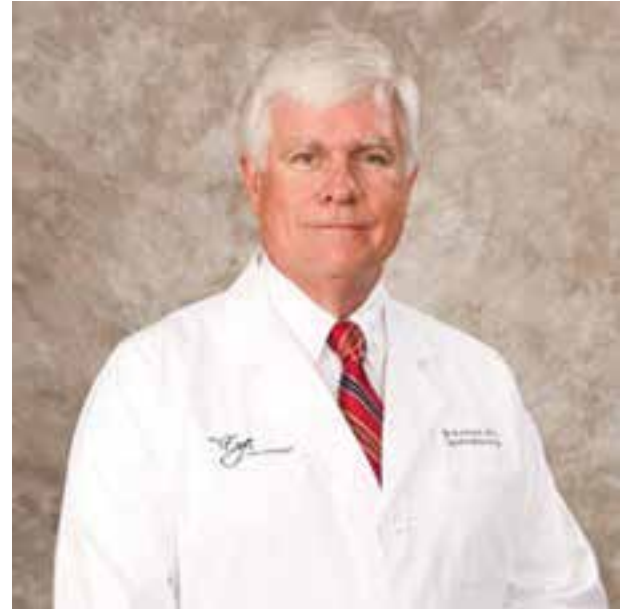


WILLIAM C. ASHFORD, M.D.

Dr. Ashford has practiced in Jackson, Mississippi since 1980, and moved his practice to Madison in April 2014. He has performed over fifty thousand major intraocular surgical cases, including Cataract IOL, Z-LASIK, DSAEK, and glaucoma procedures. He frequently flies to visit other surgeons to learn the very latest techniques. Topical (no needle), suture-less (no stitch) cataract surgery was introduced to the Jackson area by Dr. Ashford in 1993.

Dr. Ashford graduated from the University of Mississippi Medical School in 1975 and completed a Corneal Surgery Fellowship at Baylor College of Medicine in 1980. He was Board Certified by the American Board of Ophthalmology in 1981. He is a member of the AMA, the American Association of Ophthalmology, the Central Medical Society, Mississippi State Medical Association. He is a Diplomate—American Board of Ophthalmology and a Fellow—American Academy of Ophthalmology.

Dr. Ashford is married to the former Leslie Driskell of Brookhaven, MS and has three children—Emily, John Clay and Daniel.





ELIZABETH W. MITCHELL, M.D.

Board certified in ophthalmology, Dr. Mitchell has been in private practice since 1997. In addition to comprehensive eye exams, she treats patients with glaucoma and performs cataract surgery. Dr. Mitchell specializes in advanced anterior segment surgery and has a decade of experience with multi-focal implants and Z-LASIK. She also administers therapeutic Botox.

Dr. Mitchell graduated from the University of Mississippi Medical School in 1993 and completed her residency at the Medical College of Georgia in 1997. She is Board Certified by the American Board of Ophthalmology. She was a key member of Eye Physicians & Surgeons of Augusta in Augusta, GA from 1997-2000 and then served at Southern Eye Associates in Memphis, TN from 2000-2003. In 2003, she joined the team at Eye Group. She is a member of the AMA, the American Academy of Ophthalmology, American Cataract & Refractive Surgeons, the International Society of Refractive Surgeons, and the Mississippi Medical Association.



Dr. Mitchell is married to Dr. Joseph Blake Mitchell and has two daughters—Kallen and Mira.



KEVIN KOSEK, M.D.

Dr. Kevin Kosek is from Huntsville, Alabama. He was Chief Resident at the University of Mississippi Department of Ophthalmology (March-May 2010) and Chief Resident at the Department of Veterans Affairs Hospital in Jackson, MS (Nov 2009-Feb 2010). Dr. Kosek is a member of the Mississippi Association of Eye Physicians and Surgeons, the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons.

Dr. Kosek graduated from the University of Alabama School of Medicine in 2006 and served his internship and residency at the University of Mississippi Medical Center from 2006-2010. He is Board Certified by the American Board of Ophthalmology. He specializes in cataract surgery, including premium lens replacement and Z-LASIK.

He is married to the former Kim Zarzour of Huntsville, AL, and has four children— Kate, Jack, Joseph, and Leo.

