2606 South Lamar Blvd • Oxford, MS 38655
(662) 234-6551 · 1-800-237-3430

6762 Getwell Road • Southaven, MS 38672
(662) 890-1112

RAYNER EYE CLINIC, LLC

Dear Patient:

We appreciate your choosing Rayner Eye Clinic to take care of your eye care needs. Our doctors and staff will do everything in their power to make this as pleasant an experience as possible. We are committed to your eye care needs. If you have questions, please ask our staff and someone will assist you. Our policies are as follows:

OFFICE HOURS: Our office hours are 7:30 a.m. to 5:00 p.m. Monday through Thursday and on Friday from 7:30 a.m. to 4:00 p.m. (Southaven until 2pm). Any emergencies are handled through our answering service, which will page the doctor on call. You can reach our office (662) 234-6551 or the answering service 24 hours a day, 7 days a week. Please also use this number to cancel an appointment if you cannot come in. We kindly request a 24-hour notice of cancellation.

RELEASE OF MEDICAL RECORDS: In order to protect your privacy, we require an authorized signature from you to release records to anyone. If an attorney is involved, the attorney will need to obtain a notarized signature and the attorney's office will need to request the release of your medical records.

INSURANCE: If you have insurance coverage, please know that your coverage is an agreement between you and your insurance company. Please verify that we are in your insurance network of providers. We cannot know about all the individual policies available and what yours will or will not pay. In essence, you are ultimately responsible for your bill. We will give the insurance company 30 days to respond to our bill and we will bill them a second time, but after that it will be between you and your insurance company. **If you have insurance which requires you to have a referral from your Primary Care Physician (PCP), it is your responsibility to acquire the referral and provide it to us on or before the date of your service. If you do not have a referral from your PCP, you will be financially responsible for your visit.**

REFRACTION AND EXAMINATION: When vision is not normal a test called a refraction must be done to determine whether glasses can improve vision or if the reduced vision is a result of disease. A complete and thorough exam always includes a refraction, which is not covered by most insurance. Medicare and most insurance companies allow the charges but do not pay for the refractions. You will be responsible for paying the refraction fee on the day of service.

CONTACT LENS: An eye glass prescription is not the same as a contact lens prescription. New contact wearers require a fitting and follow up visit for which there will be a charge depending on the type of contact fit; likewise, patients who have never been fitted with contacts at our clinic will require a fitting and follow up visit. These charges also cover a care kit and trial pair of contact lens. Trial contacts are not available in gas permeable lens.

FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for all charges associated with my account. If I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the balance due. I also understand that my account with this provider and its doctors is considered an open account. If you have an overdue balance, payment must be made or a payment arrangement made before your visit. We do accept major credit cards.

Patient's Signature _____ Date: _____

I hereby assign, transfer, and turn over to Rayner Eye Clinic all of my rights, title, and interest to medical reimbursement benefits under insurance policy. I authorize the release of any medical information needed to determine these benefits. The authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

REVISED 07/12/2026

RAYNER
EYE CLINIC & SURGERY CENTER

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CATARACT PRE-OPERATIVE INSTRUCTIONS

THOMAS M.TANN, M.D. JONATHAN T. ZOGHBY, M.D. CASON B. ROBBINS, M.D.

PATIENT NAME: _____

DATE & TIME OF YOUR SURGERY: _____

On the date of your surgery, please go directly to the Rayner Eye Clinic. Please DO NOT arrive any earlier than your scheduled time. Also, waiting space is limited so please be mindful and bring only one person with you to your surgery.

This is a highly specialized surgery center only used for eye surgery. The nurses will explain the surgical procedure and give you written instructions on how to take care of your eye when you go home.

It takes about an hour to get you ready for surgery, so you will not be taken to surgery until about an hour after your scheduled surgery time. Your approximate time here may vary, but total average time can range from 2-3 hours.

DO NOT EAT OR DRINK AFTER MIDNIGHT (or at least 6 hours before surgery for afternoon surgeries), YOU DO NOT HAVE TO STOP YOUR BLOOD THINNERS BEFORE SURGERY If you are a diabetic, we will do a blood glucose test on the day of your surgery.

YOU MUST HAVE A DRIVER WITH YOU THE DAY OF YOUR SURGERY, and they must remain with you at the facility.

If you wear contact lenses, please contact our office for instructions.

Attention: You will receive text message appointment reminders about your upcoming surgery appointment and any post-operative appointments. If you have any questions about an appointment reminder that you have received, please feel free to contact our office. We will not change your appointment date or time without speaking to you directly first.

If you have any questions regarding your surgery, please contact our office at (662) 234-6551.

RAYNER

2606 South Lamar Blvd. Oxford, MS 38655
Phone: (662) 234-6551 or (800) 237-3430
Fax: (662) 234-0468

Dear _____,

We are looking forward to welcoming you to the Rayner Eye Clinic for your eye surgery!

Please fill out the attached packet and return it in the enclosed envelope.

IMPORTANT: Please bring all insurance cards, a photo ID, and all medications that you are currently taking with you to your appointment. You MUST have a driver that can stay with you for the duration of your visit. If you are a contact lens wearer, please contact us so that we may give you further instructions as we do ask that you be out of your contacts for a time prior to your appointment.

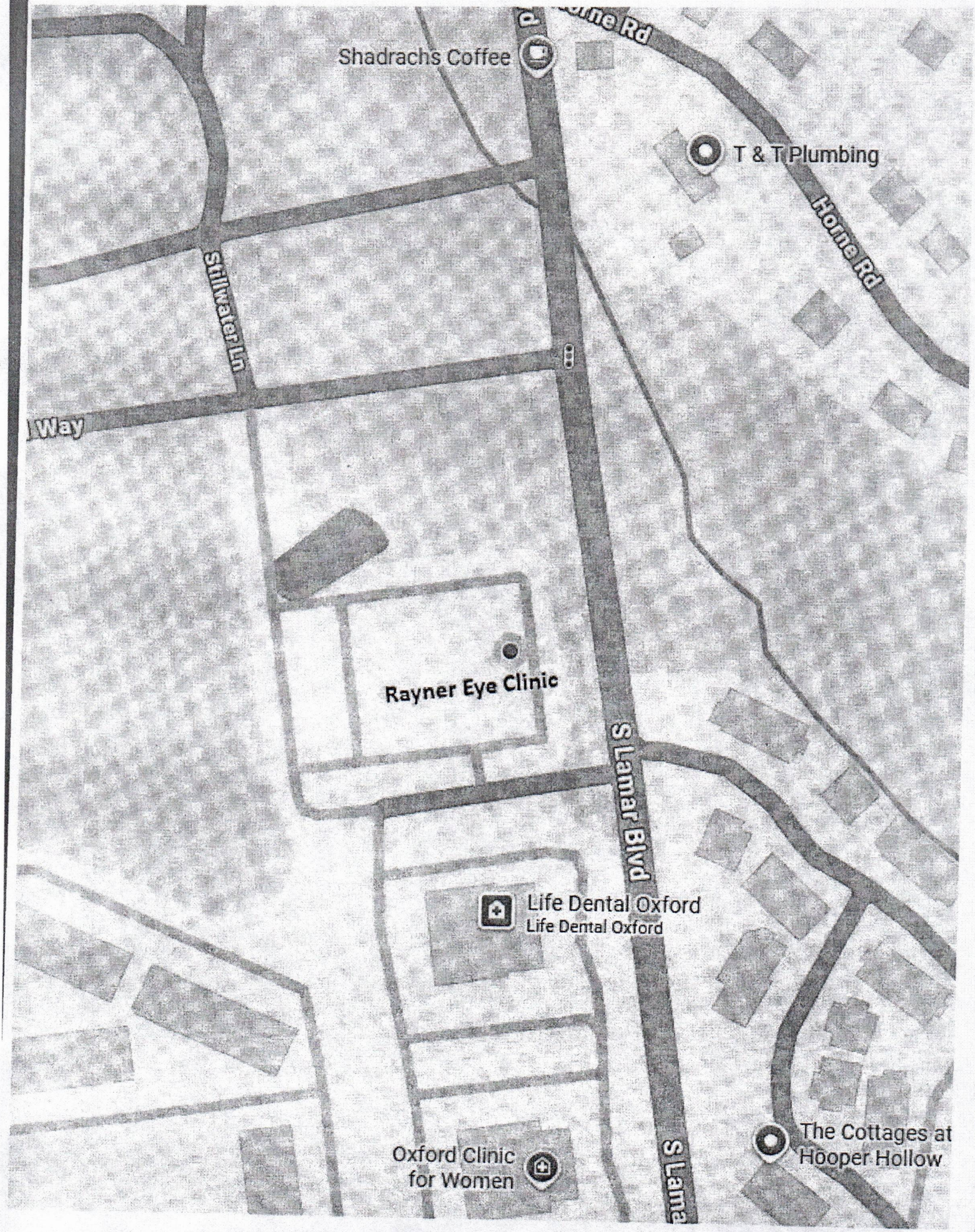
Please try to be punctual for your appointment; however, there is **no** need to arrive any earlier than your appointment time. Many surgical cases are scheduled each day, and we try our best to see our patients at their appointed time.

I will be one of the very first people that you will see during your visit. I will begin your visit by recording your medical history. After completing your medical record, you will watch a short film which explains cataracts and the procedure for that day. I will then run some tests on your eyes that the doctor will use to calculate the strength needed for the implant that he will insert once he removes the natural lens with that cataract. You will then have a complete eye examination by your surgeon, and he will answer any questions you may have. Lastly, you will go to our surgery center that is adjacent to the clinic where a nurse will be waiting for you and will direct you through the surgical procedure. All of this takes approximately three to four hours.

You will receive text message appointment reminders for your scheduled appointments such as your surgery appointment and your post-operative appointments which are typically a week later. We will not change your appointment without speaking directly to you.

We will do everything possible to make your cataract surgery a pleasant experience. Please direct any questions you may have to me at (662) 234-6551. I do see patients during clinic hours, so please allow up to 24 hours for a return call.

Sincerely,
Jessica Jones, Surgery Coordinator.


Shadrachs Coffee
T & T Plumbing
Home Rd
Stillwater Ln
Rayner Eye Clinic
S Lamar Blvd
Life Dental Oxford
Life Dental Oxford
Oxford Clinic
for Women
The Cottages at
Hooper Hollow

PATIENT DEMOGRAPHICS

Please read and answer all questions that apply.

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

MAILING ADDRESS: _____ **CITY:** _____ **ZIP:** _____ **STATE:** ____

STREET ADDRESS: _____ **CITY:** _____ **ZIP:** _____ **STATE:** ____

DATE OF BIRTH: _____ **AGE:** _____ **SS#:** _____ **MALE/FEMALE:** _____

HOME PHONE: _____ **CELL PHONE:** _____

PHARMACY INFORMATION:

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED/ OTHER

PATIENTS EMPLOYER: _____ **WORK PHONE:** _____

SPOUSE/PARENT NAME: _____ **SPOUSE'S PHONE NUMBER:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

BY GIVING YOUR EMAIL ADDRESS, YOU ARE GIVING PERMISSION FOR US TO SEND YOU AN INVITATION TO JOIN OUR PATIENT PORTAL WEBSITE. YOU WILL BE ABLE TO ACCESS YOUR RECORDS AND APPOINTMENTS. PLEASE ONLY GIVE US THE PATIENT'S EMAIL ADDRESS.

EMAIL ADDRESS: _____

I have been given the opportunity to read and/or receive the privacy notice of Rayner Eye Clinic, LLC.

SIGNED: _____ **DATE:** _____

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PATIENT MEDICAL HISTORY

Name: _____ **D.O.B:** _____ **Date:** _____

1. I am here today because (Please mark all that apply):
   - A) A doctor at this or another clinic told me I have: ☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration ☐ Retinal Problems ☐ Dry Eyes ☐ Cornea Problems
   - B) I need a checkup for: ☐ Cataracts ☐ Decreased Vision ☐ Macular Degeneration ☐ Retinal Problems ☐ Previous Surgery ☐ Diabetes
   - C) I am experiencing problems related to: ☐ Eye Pain ☐ Decreased Vision ☐ Dry Eyes ☐ Itchy/Scratchy Eyes ☐ Matted Eyes in the Morning ☐ Flashing Lights ☐ Floaters ☐ Tearing/Redness ☐ Eye Injury- Work Related? Yes or NO ☐ Other_____
   - D) ☐ I would like a Routine Eye Exam or Contact Exam. ****PLEASE NOTE, IF YOU CHECK THIS BOX AND YOU HAVE MEDICARE, YOU WILL BE EXPECTED TO PAY IN FULL FOR TODAY'S VISIT.**
2. How long has it been since your last eye exam? _____
3. Who did that eye exam? _____
4. How long have you had your present glasses? _____
5. Do you currently wear contact lenses? YES or NO Brand:_____ Power: _____

Please check the following vision problems you are experiencing:

Right	Left	Both	
____	____	____	Hazy Vision
____	____	____	Blurry Vision
____	____	____	Difficulty reading newspapers, labels or price tags
____	____	____	Difficulty seeing your phone
____	____	____	Difficulty sewing/threading a needle
____	____	____	Do you use a magnifying glass to read?
____	____	____	Difficulty seeing steps
____	____	____	Difficulty watching television
____	____	____	Vision more blurred in sunshine
____	____	____	Difficulty driving at night
____	____	____	Difficulty seeing traffic signs or traffic lights
____	____	____	Difficulty recognizing people at a distance
____	____	____	Difficulty seeing to hunt
____	____	____	Difficulty doing a job or hobby because of blurred vision
____	____	____	Seeing halos or streaks around lights
____	____	____	Seeing multiple images

Past Medical History:

Are you currently being treated for or have you in the past had problems with any of the following? If so, please check:

_____ Eye Diseases
_____ Headaches or Neurological Disorders
_____ Ear/Nose/Throat Problems
_____ Lung Disease
_____ Heart Disease
_____ Stomach Disease (GI Issues)
_____ Kidney Problems
_____ Prostate Problems
_____ Blood Disease
_____ Thyroid Problems
_____ Arthritis or Joint Disease
_____ Nervous (Psychiatric) Disorders
_____ High Blood Pressure (Hypertension)

_____ Diabetes: Circle Type- Type *1 or Type 2*
Date of Diabetes Diagnoses: _____
Reading of last A1C: _____

Primary Care Physician: _____

If you marked yes to any of the above, please explain:

_____

_____

Surgeries:

Have you ever had EYE SURGERY: YES or NO

Please explain: _____

List any other surgeries: _____

_____

Medications:

Please list all medications you are taking:

_____

_____

_____

Allergies:

Are you allergic to any medications? YES or NO
If so, what kind: _____

_____

Family History:

Has anyone in your family ever had any of the following? If yes, please list relation to you.
Glaucoma _____ Blindness _____ Macular Degeneration_____
Other Eye Disease_____ Diabetes _____

Social History:

Do you smoke or use tobacco products? _____ Have you ever? _____
Do you consume more than one or two alcoholic beverages a day? Yes _____ No _____
Do you live alone? Yes _____ No _____

Patient Signature: _____ **Date:** _____

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EYE CLINIC & SURGERY CENTER

INFORMATION RELEASE AUTHORIZATION

I hereby authorize the person(s)/entities listed below to access, discuss and/or review my medical records at Rayner Eye Clinic, LLC without further authorization. An authorized person will have complete access to my medical records, including financial records. By signing below, I am permitting the doctors and staff of Rayner Eye Clinic, LLC to discuss my medical and financial history with such authorized people. Any exceptions to this broad authorization should be noted beside each authorized person's name below.

AUTHORIZED INDIVIDUAL/ENTITY	EXCEPTIONS	DATE

PRINT Patient Name **Account #**

Patient Signature **Date Signed**