US HIPAA/CONSENT FOR THE RELEASE OF INFORMATION/RESPONSIBILITY FOR PAYMENT

I consent to the use and disclosure by the office any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including, but not limited to my employer, medical or optical provider, health plan or plan sponsor, as needed for the treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the office. (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the office.

If I desire to seek third party reimbursement for the services received, I authorize the office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the office in writing, except for any disclosure already taken in reliance of my consent to release said information. I understand that I may request the office to restrict the use and disclosure of my information; however, the office is not required to agree to my request.

Signature: _____Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

We will be happy to help you file your insurance claim forms or take assignment on your vision benefit as designated by the _____ Plan of which you state you are a member. We will also do all that we can to help you receive maximum benefits. However, in the event that the Plan Sponsor determines that you are not eligible at the time of service or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor within six months.

I authorize the release of any medical information necessary to process this claim. I also request payment of all benefits to the office listed above. I understand that I am financially responsible for all charges not covered by this assignment.

A patient's (if minor, parent's or guardian's) signature, or patient's representative's signature, requests that payment be made and authorizes release of medical information necessary to pay the claim. If signed below, patient authorizes the release of any information to the insurer or agency. The patient is responsible for the deductible, coinsurance, and any non-covered services.

Patient Name_____ Patient or Guardian signature_____

Date_____

Consent to receive SMS text messages:

By signing below, I authorize the office to send me text messages notifying me of appointments, orders ready for pickup, or other information related to my vision care. Standard data/messaging rates may apply, and I may opt out at any time by calling the office**. If declining this messaging service, please write DECLINE on the signature line.**

Signature: _____ Date: _____

Revised: May 2015

Contact Lens Policy

In order to have a valid contact lens prescription, a contact lens evaluation must be performed. A contact lens prescription expires one year after the initial exam date. The contact lens evaluation must be performed at every annual exam in order to renew your contact lens prescription. The contact lens evaluation is in addition to the standard eye examination and is billed separately. This may or may not be covered by your insurance company.

Standard: Lenses for patients who require single vision correction, with minimal or no astigmatism

Specialty: Lenses for patients who require astigmatism correction, bifocal/multifocal correction, mono-vision, or rigid gas-permeable lenses (Hard Contacts).

The doctor and staff may not know what type of contact lens a patient will require until the examination is performed. If your specific prescription requires a specialty lens, or if you ask the doctor for a specialty lens, you are responsible for the additional charges associated with the specialty lens evaluation fee, regardless of the price you may have previously been quoted. This difference is determined by your specific prescription, and is not within the control of our doctor or staff.

Contact lens evaluation fees are due on the date of the exam, and are non-refundable. If you decide to upgrade to a specialty lens, or if the doctor determines that a specialty lens is required to address your visual needs or problems, then you may be responsible for the additional charge for a specialty fit.

Do you wish to have a contact lens exam today (there is an additional charge): Yes ____ No_____

(This charge may or may not be covered by your insurance. If you are uncertain, be sure to ask our staff BEFORE your examination)

Dilated Eye Examination:

Dilation is a medical procedure which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). With dilation the doctor has the opportunity to evaluate and diagnose eye health problems before symptoms occur. It is recommended that all new patients are dilated, and again every 2 to 4 years thereafter, unless certain conditions require close monitoring. **SOME PATIENTS MAY EXPERIENCE LIGHT SENSITIVITY AND BLURRED VISION FOR 2 TO 6 HOURS OR LONGER.** If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You may have difficulty driving after the procedure, if you feel more comfortable being driven, please make arrangements to do so. In rare instances, patients may experience pain of other side effects. If this should occur, please seek medical attention immediately. Please advise our doctor if you are pregnant or nursing at this time. If you have any other health conditions that may affect your response to these tests or questions regarding dilation, please consult our doctor for additional information. Please sign your initials below to indicate you have read and understand the above.

I acknowledge I have read the above and understand **YES** or **NO** **Initials: _____**

Revised Jan 2020