FAMILY EYE CENTER VISION SOURCE
WELCOME TO OUR OFFICE!

PATIENT NAME:	DATE OF BIRTH: / /
ADDRESS:	
SS#:	PHONE NUMBER:

We are now making greater use of email to communicate with our patients. To sign up for on-line services such as scheduling an exam, appointment reminders and appointment confirmations, or to give us feedback once services are provided, please print your current e-mail address below:

CONTACT LENS POLICY
(APPLICABLE ONLY IF YOU ARE INTERESTED IN CONTACT LENSES)

Our doctor performs a comprehensive eye exam to check the overall health of your eyes, as well as additional testing that determines the strength and type of contact lens that best suits your eyes. This also includes a pair of trial contact lenses and a 1-week progress visit to check the fit of your contacts and the health of your eyes.

Fees that are paid for examinations, contact lens evaluation/fitting, and progress checks for contacts lenses are non-refundable. A period of 30 days is allowed for all contact lens follow-up visits. There will be a separate charge for any additional visits past the 30-day time frame. Your prescription is finalized once you have worn the contacts and expressed to us that you would like to proceed with the order. Once the order is placed, the contact lens companies do not take back the contacts so we are unable to provide a refund for these boxes.

Patient's Initials _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

In the course of providing services to you we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct healthcare operations involving our office.

We have comprehensive notice practices that describe these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices the use and disclosure of your health information is necessary for you to receive follow up care from this office or another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing of claims, or obtain payment, our submission of claims to 3rd party payers for claims reviewed, determination of benefits and payments, our submission of your health information to auditors hired by 3rd party payers and insurers among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated when our privacy practices changes. Whenever our practices change you can get an updated copy here at our office or from www.visionsource.com website.

When you sign this consent you signify you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. By signing you signify that you have no other health or vision insurance (or have provided us all insurance information) and agree that since there is no guarantee of payment by an insurance company you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed healthcare operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notices of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notices of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATION.

Date_____ Signature of Patient_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

_____ _____
Relationship to Patient Print Name

INSURANCE CONSENT

I, _____, give consent to this practice to release my medical records (self, patient, or guardian) above specified to _____.

(Insurance Company Name)

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request for the purpose of healthcare operations (including but not limited to, provider review function, claims payments and quality assessment). I also understand that I may revoke this consent by written request at any time with this doctor. If revoked it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Signature: _____. Date: _____.

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Not making your appointment inconveniences other patients. Please call us at least 24 hours in advance if you need to move your appointment time or date in order to avoid a $25 cancellation fee. We understand that emergencies do happen therefore we allow patients the following before we decide to no longer provide services: If a patient does not show up for their appointment for 3 consecutive visits or cancel the same day of the appointment up to 3 times.

FINANCIAL POLICY

Thank you for choosing our practice! Our office staff is very committed to successfully treating and caring for your medical needs. However, it is very important to us that you understand payment of your bill is part of this treatment and care. We ask that you carefully read and initial all of the following numbered items.

1. _____. If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all services rendered. You will be responsible at the time of service for the payment of:

    - **The annual deductible**
    - **Co-payments**
    - **Charges for non covered services**

Before services are rendered, our office will call your insurance company to verify eligibility and benefits. However, verification of benefits is **NOT** a guarantee of payment. You will be billed if:

- **We obtain a denial from your insurance company**
- **We have not received payment from the insurance company within 60 days of our filing your claim.**

We will make every effort to contact your insurance to verify benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to, punctual closures, glaucoma scans, visual fields or other medically necessary testing.

2. _____. If you purchase glasses, contact lenses, or other supplies from our offices, please understand that the products/supplies are non refundable**. All materials are to be paid in full prior to ordering**. If there is a balance due for any other service or material purchase from a previous date, it **must be paid** prior to ordering new product. We will be happy to adjust your glasses, replace nose pads, and screws at no charge. A shipping charge of $10 is required when ordering product including warranty replacements. Some exclusion may apply.

3. _____. If you have no health insurance, payment is expected in full at the time of service

4. _____. There will be a $35 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately. We will accept payment in the form of Credit card, cash or money order. Should you fail to reply within 7 days, our office will forward the balance to Telecheck for collections. There may be additional fees from Telecheck as well.

5. _____. We are Medicare participating providers; therefore, we will bill Medicare directly. However, as with any insurance carrier, you will be responsible at the time of services for payment of:

    - **The annual deductibles**
    - **Co-payments**
    - **Charges for non-covered services**

You will also be asked to sign an Advanced Beneficiary Notice (ABN) form in the event a service is provided, which we know is not covered by Medicare. For your convenience we accept cash, pre-printed NON temporary checks, Visa, MasterCard, American Express, Care Credit and Discover. If you have any questions please do not hesitate to ask us. We are here to assist you in any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____

Signature (If minor, parent must sign) Date