WELCOME TO OUR OFFICE

PLEASE PRINT

☐ NO CHANGE IN ADDRESS

NAME	HOME PHONE
ADDRESS	WORK PHONE
CITY, STATE, ZIP	EMAIL

Please indicate your reasons for visiting our office today: (check all that apply)

☐ **General Exam**
(Comprehensive Eye Examination, without Contact Lens Evaluation)

☐ **Blurred Vision**

☐ **Contact Lens Evaluation**
(Comprehensive Eye Examination, Contact Lens Evaluation & Contact Fitting)

☐ **Interested in Contact Lenses**
(Would like to discuss with doctor)

☐ **Other** _____

We are occasionally asked for a contact lens prescription after a general eye examination or after the initial contact lens fitting visit. Determining your exact contact lens prescription requires a more specialized method of testing that is not involved in a general eye examination. Your prescription cannot be finalized until the contact lenses have been worn for a period of time to ensure that no lens design changes will be needed. After the completion of one week of successful contact lens wear monitored by a progress visit, we will release the final contact lens prescription upon request. If you have any questions about contact lenses, fees or prescription release, please ask our staff or doctors. **ALL PRESCRIPTIONS FOR GLASSES AND CONTACTS EXPIRE IN ONE YEAR, AND WILL NOT BE RELEASED THEREAFTER.** I am aware that I have 90 days after my contact lens exam to make any adjustments to my prescrition RX or brand, any visit past 90 might include a charge. I also acknowledge the prescription will not be released after one year and that I have informed the office of all my insurance coverage.

PATIENT INFORMED CONSENT

I understand the doctors of Arboretum Vision Care recommend dilation/Optomap to more thoroughly evaluate the internal health of my eyes. **Without dilation/Optomap, serious eye diseases such as diabetes, retinal detachment or malignant tumors (which can result in blindness, loss of an eye, or even death) could be present and not seen by the doctor.** I understand there is not an alternative procedure that can replace dilation of my pupils. **I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions of my optometrist, Arboretum Vision Care and their employees, officers, directors and agents.** I also understand that if my medical history or exam findings warrants dilation, my doctor has the authority to insist on the procedure in order to continue with the examination. I understand dilation may make driving difficult for several hours and I have made appropriate arrangements. I understand that I need to be careful walking due to possible effects of dilation on my depth perception.

Please check one:

☐ I agree to dilation today.
☐ I agree to Optomap today.
☐ I prefer to reschedule dilation
☐ I refuse dilation
☐ I refuse Optomap

I hereby confirm that the above information is correct to the best of my knowledge.

Payment:

I accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card. I also understand there will be a charge for returned checks. *** Any balances older than 120 days may be subject to collection placement fees which will be charged to the responsible party. If we are forced to send your account to collections, a 50% fee will be added to your balance.**

Patient, Parent or Guardian Signature _____ Date _____

Consent to Treat, Assignment of Benefits & Notice of Privacy Form

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our office Manager. We are dedicated to providing the best possible vision care and service to you and regard your complete understanding of your financial responsibilities as an essential element of you care and treatment.

Eye Care Services: Office provides a full scope of eye care services including "**Routine Vision Care**" (ie: check-ups, glasses and contacts), as well as "**Medical Eye Care**" services such as treatment for eye infections, dry eye, and lid disease, treatment and evaluation of ocular allergy, cataracts, glaucoma, diabetes and trauma related care. Depending on the nature of your visit, we may be able to bill you vision insurance, your medical insurance or both. Please present all of your insurance information to receptionist upon arrival.

Medical Eye Care: PPO's – Your Medical insurance may be able to be billed for certain eye conditions and procedures that your insurance company deems medically necessary and has included in your policy. You will be given a "Health History" to fill out. Even with this information, it is impossible for our office to determine with any certainty what, if any, charges will be covered by your insurance company. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance.

HMO's – If an HMO patient follow the referral or authorization guideline before their visit to a specialist, medical necessity is established and the service is a covered service as determined by your insurance company

1. **Consent for Treatment:**
   By signing this form I consent and authorize Arboretum Vision Care to treat me. I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and or treatments prescribed by my doctor, his/her assistants or designee necessary in his/her judgment. For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or legal guardian for payment.
2. **Professional Service Insurance Release & Assignment of Benefits:**
   I authorize the release of any medical information necessary to process insurance claims for medical services provided to me or my dependents by Arboretum Vision Care. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full or remaining patient balances should my insurance carrier determine that services I received are not covered.
3. **Insurance:**
   We participate in many insurance plans. If you are not insured by a plan we do business with or do not have an up-to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information, we bill primary and secondary insurances. Please contact your insurances company with any questions you may have regarding your coverage. **If your insurance company does not pay your claim within 30 days of it being filed, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay within 90 days you will be responsible for payment in full.**
   - **Insurance Overpayment: Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit.**
4. **Referral:**
   I understand that if my insurance requires a referral from my Primary Care Provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, it will be my responsibility to contact my Primary Care Provider's office the same day and obtain the necessary referral, dated for the date of service. I also accept full financial responsibility for all

charges incurred for services received on the day of service, if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

5. **Non-Covered Services:**
   Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is **Refraction**, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge you refraction fee separately from you exam.
6. **Contact Lens Exam:**
   Contact lens "**fitting**" is not included in a complete eye exam; it is a separate procedure with an additional charge. Payment for the "fitting" will be expected at the time of service. The fitting is to determine the best contact lens for your eye's curvature.
7. **Patient Authorization:**
   I hereby authorize Arboretum Vision Care to: (1) release and send copies of my records to other physicians as needed for continuity of care. I understand this is a group practice and other eye doctors may be involved in my care. (2) Process insurance claims generated in the course of exam or treatment; (3) allow a photo copy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I understand that Arboretum Vision Care's records contain protected health information about me and as such, are highly confidential. When appropriate, this office may use medical records for non-treatment purposes (research, public health, and some operational activities).
8. **Payment:**
   I accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card. I also understand there will be a charge for returned checks. * **Any balances older than 120 days may be subject to collection placement fees which will be charged to the responsible party. If we are forced to send your account to collections, a 50% fee will be added to your balance.**
9. **Authorization to Communicate Private Health Information:**
   I hereby authorize Arboretum Vision Care to leave messages on my answering machine, voicemail, or with individuals who answer the phone numbers provided on the patient Registration Form.
10. **HIPPA (Health Insurance Portability and Accountability Act):**
    In compliance with the Health Insurance Portability and Accountability Act (HIPPA), we have on HIPPA Notice of Privacy Practices on display in the reception area or the front desk. This document describes the detail how information about you, the patient, can be used with our office and with others who need to know the reason for treatment, payment, and/or healthcare operations. If we were to disclose your information for any reason, we would first need your written approval. **A printed copy of the HIPPA notice will be provided upon request.**

By signing below, I hereby confirm that the above information is correct to my best of knowledge. I have read the above and authorize Arboretum Vision Care to treat, bill and share my medical information discussed about. I have read and understand the financial policy of practice and HIPPA.

Signature of Patient or Responsible Party if a Minor Date Relationship to patient