CROZET EYE CARE, OPTOMETRISTS OFFICE POLICY

Patient Name: _____ **Date of Birth:** _____

FINANCIAL RESPONSIBILITY

As a courtesy to you, we will submit the billing for today's services to your insurance carrier, if we are a participating provider for that plan. Any balance not paid by your insurance carrier is your responsibility, and you will receive a statement for payment. Unless prior arrangements are made, full payment is due at the time of service. For your convenience, we accept MasterCard and Visa. Copayments and an estimate of what your insurance will not cover will be collected at the time of your appointment.

I understand that payment is due at the time services are rendered. For delinquent accounts, I agree to be responsible for any reasonable collection fees incurred by Crozet Eye Care, Optometrists to collect payment for materials and/or services rendered. I understand that if the account is not paid within 90 days from receipt of first statement, the amount will qualify for placement with our outside collection agency.

I have read and understand the above (Initials) _____

CONTACT LENS PATIENTS

Please be aware that the fitting or evaluation of contact lenses is performed in addition to your eye exam and there is a separate fee for this service. The fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. **It may not be covered by insurance.**

I have read and understand the above (Initials) _____

PREVENTATIVE SCREENINGS

Crozet Eye Care wants to provide our patients with the highest quality care available. In our office we utilize Optomap® retinal imaging and the iVue iWellness scan. Each provide invaluable information for early detection of disease. Our doctors want ***all*** patients to have both Optomap® and iWellness. They will be done annually unless a waiver is signed. The fee is **$39** and is not covered by insurance. **I understand that by initialing this form, I am authorizing these scans.**

I have read and understand the above (Initials) _____

APPOINTMENT POLICY

In fairness to other patients and the doctor, we require at least 24- hour notice to cancel an appointment. You may be charged $50.00 for each appointment that was missed or not canceled with 24- hour notice. Missing more than two appointments without providing 24-hour notice is grounds for discharge from the practice.

I have read and understand the above (Initials) _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that the privacy practices of Crozet Eye Care, Optometrists are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I may view and/or print a copy of this Act at my convenience by visiting www.crozeteyecare.com. I also understand that I may request a copy of this Act from the front office staff.

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to Crozet Eye Care's use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. Insurance claim information is transmitted via secure internet connection. Crozet Eye Care may also send me mail correspondence, such as recall notices.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

FOR OFFICE USE ONLY

I have had full opportunity to read and consider the contents of the Consent form and Notice of Privacy Practices. I do not give my consent to disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ Date: _____

CROZET EYE CARE, OPTOMETRISTS

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Anthem and Medicare)

- **Vision care plans** only cover routine vision exams which include basic screening for eye disease along with eyeglasses and contact lenses. They do not cover diagnosis, management or treatment of eye diseases.

- **Medical insurance** must be used if you have any eye health problem or systemic health problem that has ocular complications. ***Your doctor will determine if these conditions apply to you, but some are determined by your case history.***

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits between your medical and vision plans as it states in our contracts with them.

- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____

Patient signature (parent if child) Date