AUTHORIZATION / ACKNOWLEDGMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ ____/____/____ _____

Signature of Patient/Guardian/Personal Representative ***Date*** ***Description of Guardian/Personal Rep***

FINANCIAL POLICY

- Payment is due at the time of service. If you are a member of an HMO or PPO for which we are providers, you must inform us **prior** to your visit.
- It is the responsibility of the patient to obtain referral and authorization numbers from your primary care physician.
- We request payment at the time of service for any non-covered services, such as routine exams, contact lens fitting fees and contact lenses.

ROUTINE VISION EXAM

Routine vision exams are not covered on all insurance policies. Some vision coverage is a benefit separate from any medical coverage. It is the responsibility of the patient to obtain routine vision coverage information, including participating providers prior to your visit. Payment at the time of service will be required for routine vision exams if non-covered by your insurance plan.

REFRACTION WAIVER

Before a refraction is performed, your vision is checked by asking you to read an eye chart. If you are unable to accurately read the 20/20 line on the chart a refraction may be performed. To perform this test you will be asked to look through a series of lenses in graded powers to determine which provide the clearest, sharpest vision. A refraction is essential in order to determine if the decrease in vision is due only to a need for glasses, or if another medical reason exists. This procedure is considered non-medical and is not covered by Medicare or most insurance companies. This is because the information it yields can be used to prescribe glasses, although this is often not its purpose. We hope you understand that the importance of determining your best corrected vision is essential to your eye exam and proper diagnosis.

I authorize the release of any medical information necessary to process all claims and the release of payments for medical benefits to my physician. I understand that I am financially responsible for any charges not covered by my insurance.

_____ ____/____/____

Signature of Patient/Guardian/Personal Representative ***Date***

CONTACT / RELEASE OF INFORMATION

In the event that Eye Associates of Central Texas needs to contact you (the patient) regarding an appointment, lab result, medication or for any other reason, it is permissible to:

☐ Leave a message on an answering machine

☐ Speak with spouse/significant other

☐ Speak with other family members

☐ Other

Name: _____

Relationship to Patient: _____

_____ ____/____/____

Signature of Patient/Guardian/Personal Representative ***Date***