PATIENT CONSENT AND RESPONSIBLITY FORM

The patient understands that medical records are confidential. He/she is allowing the medical information to be released for purposes of treatment, payment, or health care operations, including but not limited to, provider review functions, claims payment, and quality assessment. The patient also understands that he/she may revoke this consent by written request, at anytime, 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 your consent. Under the Department of Health and Human Services' "Privacy Rule", the associates affiliated with Miraflores Eyecare has the right to refuse treatment if the patient refuses to disclose personal health information. The patient acknowledges that he/she is providing accurate information to the associates of Miraflores Eyecare, and if the information is inaccurate or lacking, treatment may be delayed or ceased until the necessary information is obtained. When it is appropriate, the minimum necessary information will be provided to only those entities in need of the health care information and information about treatment, payment or health care operations, in order to provide health care that is in the patient's best interest. We can furnish a copy of our full HIPPA disclosure at your request. This is just a summary.

As a patient of our clinic, you have a right to a copy of your examination subject to photocopy, mailing, and/or electronic data submission fees. Copies may take up to 30 days from request. We will need a signed records release form and payment, if any, in order to process the request.

The patient hereby authorizes Miraflores Eyecare and its business associates for treatment of him/herself or those whom he/she is the legal guardian or representative. The patient will attempt to abide by the guidelines recommended by the associates of Miraflores Eyecare for the purpose of treatment which includes but not limited to follow-up appointments, referral care, and prescriptions as prescribed. The patient is accountable for any delay of treatment due to the disregard of the recommendations of Miraflores Eyecare. The patient is aware there may be additional office fees if he/she continues treatment at Miraflores Eye Care or any further clinic.

ADVANCED BENEFICIARY NOTICE (ABN)

We anticipate that Medicare or your health care insurance will not pay for the item(s) or service(s) that you received at Miraflores Eyecare and its associates. Medicare or your health care insurance does not pay for all your health care costs. They only pay for covered items and services when their rules are met. The fact that Medicare or your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

An account of your service provided by the doctor can be given to you on an insurance form. Realize, this form does not mean services provided by Miraflores Eyecare and its associates guarantees payment by Medicare or your health insurance. You are responsible of knowing what procedures your health care insurance covers. You are allowed to submit this insurance form to your insurance for reimbursement to you. Your insurance has the right to review your file in our clinic if there is any question in billing, regardless if the doctor is a willing provider. Most insurance do not cover routine ocular examinations, thus, it is the patient's responsibility for payment of services rendered without billing your insurer. Miraflores Eyecare will ONLY submit a claim form for insurance on the day of service and is allowable by your insurance company.

NOTICE OF PAYMENT AND SERVICE AGREEMENT

An eyeglass prescription expires in 2 YEARS (unless otherwise noted) from the initial comprehensive examination. Any change in prescription may be re-checked with no additional fee up to 60 DAYS from the initial exam. An excess of 60 days will be subjected to a refraction charge determined by the doctor. A prescription check/change request after 6 months may be subject to another need for a full comprehensive examination and its associated fees.

For contact lens wearers, a contact lens prescription expires 1 YEAR (unless otherwise noted) from the initial comprehensive and fitting examination. Any change in prescription and/or fitting may be re-checked with no additional fee up to 60 DAYS from the initial fitting examination, assuming follow-up treatments were satisfied. There may be an additional fee if the patient is re-fit into customized contact lenses like torics, gas perms, bifocals, etc. Complying with follow-ups is the responsibility of the patient, and thus, if the delay in follow-up recommended by the doctor exceeds 4 weeks from the initial fitting, the 60 DAYS of no fee is not applicable. The patient will be subject to a fee per account after the 4 weeks. The patient has a right to decline a follow-up, and in this event, the prescription is considered final. Any changes will be subject to the $40 or higher fee. A prescription check/change request after 6 months may be subject to another need for a full comprehensive examination and fitting and its associated fees.

EXAM FEES ARE NON-REFUNDABLE.

AFTER HOURS CARE/DOCTOR AVAILABILITY

Although we value our patients, our staff is not available except during business hours posted in our clinic. We do not offer after hours care nor do we provide ambulatory services for patients unable to drive to our clinic. It is the patient's responsibility to provide his or her own transportation. If the doctor is not available and there is an emergent need of care, the doctor advises you to contact the staff to direct you to the correct provider. If you are not able to reach us, we recommend that patients call Dr. Charles Optical at (678) 974-2900 for eye emergencies when the doctor is not available or seek another eye care provider within the vicinity. For afterhours care, please go to the nearest Urgent Care or Emergency Room.

I have read the above consent for release of information and office policies. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent. We have a copy of our HIPPA policies that you may request to view or received a copy for your records at any time. We will attempt to update you on any changes to our policies before the start of treatment. **PLEASE SIGN BELOW TO ACKNOWLEDGE YOU HAVE READ OUR POLICIES.**

**** _____ **** Date: _____

ALL PATIENTS MUST READ AND SIGN

(***we reserve the right to decline insurance we do not participate even if we are listed as a provider***)

FINANCIAL POLICY (for all patients)

--Miraflores Eyecare cannot extend credit to patients since we are not creditors. All professional fees must be paid in FULL at the time of service. We accept cash and most credit cards.

--Insurance must be pre-authorized before your appointment. We need at least one full day to gather all the needed information about eligibility. If you decline our pre-authorization guidelines, you are considered self-pay, and we are considered a non-participating provider. Any monies paid by your insurance company to us will not be accepted. Your exam may be delayed or rescheduled if not all information is available and eligibility verified before appointment.

--Patient is responsible for payments or fees that insurance does not reimburse. If there is failure to do this 30 days from the explanation of benefits (EOB) or invoice from insurance, the patient account is considered delinquent and follows the same guidelines of non-payment. Insurer will be informed.

--Non-payment by patient 30 days from exam will be considered delinquent and your file will be closed. Our clinic will not send deliquent invoice BUT a $50 fee will be added for delinquency. Patient is responsible if insurance reimburses patient in lieu of doctor. The patient must pay the amount to the doctor. If there is failure to do this 30 days from the check date, the patient account is considered delinquent and follows the same guidelines. Insurer will be informed.

I, undersigned, certify that if I (or my dependent) have insurance coverage that I will assign all insurance benefits directly to Miraflores Eyecare. Furthermore, I understand that I am financially responsible for all charges whether or not paid by insurance or if I am self-paying. The physician or supplier agrees to accept the charge determination of my carrier as the full charge if submission is done by Miraflores Eyecare, and I am responsible for the deductible, coinsurance and non-covered services. If I submit the claim myself, I accept any money reimbursed as paid in full. I hereby authorize the doctor to release all information necessary to my insurance carrier and related parties to secure the payment of benefits. I authorize use of this signature on all insurance submission. By signing this, I also agree that **EXAM FEES ARE NON-REFUNDABLE,** have read the financial policy and *a*cknowledges that payment is due at the end of the service per day unless otherwise noted.

_____	Self	___/___/____
Signature	Relationship to patient	Date

FOR INSURANCES THAT WE ARE NOT PARTICIPATING PROVIDERS:

*The patient understands that he/she is being seen at Miraflores Eyecare without verification of eligibility for services by your insurance company and without a required referral from your medical Primary Care Physician. He/she understands that if his/her eligibility cannot be verified or if he/she does not obtain the proper referral form when required, he/she will be financially responsible for payment of all charges incurred for services received at this office. All **EXAM FEES ARE NON-REFUNDABLE**.*

AUTHORIZATION FOR DILATION

It is highly recommended that a patient includes a dilation in managing his/her eye health. Without this recommended procedure, only 60-70% of the internal system of the eye can be viewed. In several cases, this can be a reasonable assessment of eye health. However, the other portion of the eye not observed could have a retinal detachment, eye tumor, or any peripheral eye disease that cannot be detected without dilation. The procedure is highly indicated for the following persons: » First eye exam or last eye exam was over 5 years » Last dilation was over 2-3 years ago » High prescriptions » Developing cataracts »Recent onset of flashes of light or numerous "floaters" » Unstable vision or complete vision loss » Eye disease being followed or history of one » Family history of eye disease » Severe head trauma » Severe or unexplained headaches » Only one functional eye » System conditions (hypertension, diabetes, MS, etc.) » Over the age of 40

The side effects are minimal with dilation and not long-lasting. Usually, the effects are gone within 24 hours. The two common effects are: 1. Blurred vision up close for 4-6 hours. 2. Sensitivity to bright lights (especially sunlight) for 4-8 hours. Sunglasses will be provided if you do not have one. Please wear them when driving.

If any eye pain or extreme nausea is experienced after the examination, please call an eyecare specialist or immediately go to the nearest urgent center for care. Inform them of your dilation.

THERE IS NO CHARGE OR FEE FOR THIS PROCEDURE

◯ ACCEPT DILATION ◯ DECLINE DILATION ◯ RE-SCHEDULE DILATION

OCULAR TOMOGRAPHY iWellness SCAN

The doctor has added one the latest technologies for your comprehensive eye examination. This clinic now has access to take scans of your retina where many detrimental pathologies occur like diabetes, high blood pressure, glaucoma, macular degeneration, posterior eye tumors, blocked arteries, possible brain tumors affecting the optic nerve, etc. This procedure is very simple and can sometimes be done without dilation (the doctor will inform you if dilation is necessary for better acquisition). View of the results is immediate. Mailed photocopies of retinal scans are $7.00 additional, and an E-mail copy of the scan is $3. OCT scans are effective in monitoring changes in your blood vessels, optic nerve, macula, etc. It is highly recommended for patients at risk for or presently have diabetes, hypertension, glaucoma, and macular degeneration to have retinal scans at each visit. For 'healthy' patients, a retinal scan is recommended every 2 to 5 years (depending on age).

THE FEE FOR THE RETINAL OCT IS $15 FOR PATIENTS OF MIRAFLORES EYECARE.
(Your insurance may not cover the fee)

◯ ACCEPT RETINAL OCT SCAN ($15 fee) ◯ DECLINE RETINAL OCT SCAN

◯ REQUEST MAILED PHOTOCOPY OF SCAN ($7.00)

◯ Request Email of scan ($3)

◯ NO COPY OF SCAN REQUESTED

*****Note: CERTAIN DISEASES LIKE CATARACTS MAY LIMIT THE QUALITY OF THE IMAGE. IF IMAGE IS DISTORTED, YOU WILL NOT BE CHARGED AND IMAGES WILL NOT BE SAVED.*****