CONSENT NOTICE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that I have certain rights to privacy. By signing this form, you acknowledge that you have reviewed our Notice of Privacy Practices and disclosures of protected health information for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

With my signature below, I hereby authorize Bright Side Eye Care to disclose my medical information so that the practice may provide treatment, seek payment from third parties for such treatment, and generally carry on the health care operations of the practice (e.g., quality assurance). I also authorize the disclosure of my medical information to insurers and providers outside of this practice when necessary for purposes of my treatment, payment for such treatment, and for their health care operations.

60 DAY PRESCRIPTION GUARANTEE

There are many factors that can affect your visual acuity. Our doctor honors a guarantee on your glasses and contact lens prescriptions for up to 60 days from your initial examination. Fees are separate for your comprehensive exam for glasses and contact lens evaluation. Additional visits after 60 days from the examination date will be subject to our usual and customary fee of $45 per visit. The additional visits are not covered by insurance.

Due to the customized nature of spectacle eye wear, all sales on glasses are final and non-refundable.

NOTICE OF FINANCIAL POLICY

Payment for service is due, in full, at the time of service. All outstanding accounts turned over to a collection agency will be assessed an additional charge of $50.

I understand and agree to the consent notices and financial policy outlined above. Our doctor is therapeutically licensed to perform an ocular medical health evaluation at every exam. Medical findings may be billed through your medical insurance policy. Furthermore, I understand that if my insurance eligibility cannot be verified or if I do not obtain the proper physician referral, I will be financially responsible for payment of all charges incurred for services received at Bright Side Eye Care.

Patient/Guardian Name (Print): _____ Date: _____

Patient/Guardian Signature: _____ Relationship: _____