Elite Eye Group

Elite Eye Group recommends a state-of -the-art digital retinal scanning technology that allows us to view the inside of your eye *without* the use of dilation drops. **OPTO**MAP allows our doctors to evaluate your retina for problems such as Macular Degeneration, Glaucoma, Diabetes, High Blood Pressure, Melanoma, Retinal Detachments, and much more. The scanning system is completely safe for children and adults. The images can be compared year to year to accurately monitor for changes and it allows you the opportunity to see the inside of your eyes just as the doctor sees it!

There is an additional fee of $39 for the **OPTO**MAP scan. In most cases, this scan is not covered by insurance. Dilation may still be required in some cases such as with Diabetes or Glaucoma.

OPTOMAP	Dilation
-NO blurred vision	-Blurred near vision for 4-6 hours
-NO light sensitivity	-Light sensitivity for 4-6 hours
-Scan takes less than 2 minutes	-Longer examination
-You can see your retina	-Only the doctor can see the retina
-Digital image that can be reviewed & compared each year	

▢ I elect to have the **OPTO**MAP digital scan of my retina today instead of dilation at a cost of $39

▢ I prefer to have a dilated exam of my retina

____ _____/_____/_____

Patient Signature Date

HIPAA Privacy Acknowledgement of Notice of Privacy Practices

I, ____________________ have been presented with the Notice of Privacy Policy of Elite Eye Group and have been offered a copy of such policy to keep for my records.

I decline receipt of the written policy	__________________ Patient signature	____/____/____ Date
I accepted a copy of the written policy	__________________ Patient signature	____/____/____ Date

With whom do we have permission to discuss your medical information with?

Name ___________________________ Relationship _______________ Date ____/____/____

Name ___________________________ Relationship _______________ Date ____/____/____

Name ___________________________ Relationship _______________ Date ____/____/____

Name ___________________________ Relationship _______________ Date ____/____/____

Refraction Fee (with medical insurance)

The refraction is the portion of your comprehensive eye exam in which your eyeglass or contact lens prescription is determined. If your insurance does not provide routine eye exams this fee of $35 is due at the time services are rendered.

I have been notified that my refraction done today will not/may not be covered by my insurance and I assume responsibility for this fee.

____ ____/____/____
Patient Signature Date

I have read the above and do not want the refraction portion of my eye exam done today.

____ ____/____/____
Patient Signature Date

Statement of Responsibility/Financial Assignment & Release

If you have health insurance of any kind, please read our policy and initial next to the (➢):

We will do everything we can to help you obtain reimbursement from your insurance carrier; however, the basic responsibility is yours. As a courtesy to you, we will send claims to your insurance company. However, we cannot accept the responsibility for negotiating claims with insurance companies or other parties.

Please check with your insurance company to see if a **referral** is required for your visit. If one is needed, it is your responsibility to obtain one **prior** to your visit. If no referral is issued, we will have to reschedule your appointment. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. ➢______

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. You agree to be financially responsible to reimburse all fees for services not collected in full at the date of service should your insurance or vision plan denial in part or in the entire claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. ➢______

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. ➢_____

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. ➢______

If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists. ➢______

I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered. ➢______

I agree this office, with NO EXCEPTIONS will not back date and file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits. ➢______

____ ____/____/____

Patient Signature Date

Authorization for Treatment & Patient Financial Responsibility Form

Thank you for choosing our practice as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies.

Authorization for Treatment & Payment of Medical Benefits

- I understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my insurance. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.

Patient Authorization

- By my signature below, I authorize Elite Eye Group to release medical and other information to the necessary insurance companies and third payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to Elite Eye Group. I understand that I am financially responsible for charges not covered or applied to my deductible, or denied in full by my insurance plan.

____ ____/____/____

Patient Signature Date