ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that The Eye Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ I have read or had explained to me The Eye Clinic's Notice of Privacy Practice and agree to continue my care with The Eye Clinic under said terms.

OR

- ☐ I was given the opportunity to read The Eye Clinic's Notice of Privacy Practices and declined but wish to continue my care with The Eye Clinic under the terms of The Eye Clinic's privacy policies.

OR

- ☐ I have read or had explained to me The Eye Clinic's Notice of Privacy Practice and do not wish to continue my care with The Eye Clinic under said terms.

OR

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  ____

I HAVE READ, I FULLY UNDERSTAND, AND I AM VOLUNTARILY SIGNING THIS FORM.

____ ________________
Patient, Representative, Guardian Date

____
Relationship to Patient

AUTHORIZATION TO COMMUNICATE W/ FAMILY OR OTHER PARTIES

If you wish that any information be discussed with someone OTHER than yourself, you must list their names below. Without this release The Eye Clinic cannot and will not discuss any information with anyone but YOU.

Name: ____________________________ Relationship: ________________ Phone: _______________

Name: ____________________________ Relationship: ________________ Phone: _______________

Information allowed to be discussed:	Medical:	[] All [] Other	(If you mark Other,
	Billing:	[] All [] Other	please see front
	Appointments:	[] All [] Other	desk staff)

The purpose of this authorization is:

[] At the request of the patient / patient's representative [] Other (state reason)

This authorization is valid for _________ days / months / years. If no date is provided, this authorization is valid for one year.
You have the right to revoke or change this authorization at any time; such change will only apply to information not already released. Should you wish to revoke or change this authorization, you must submit in writing to The Eye Clinic. You understand that you do not have to sign this form in order to receive treatment from The Eye Clinic.

____ __________________________
(Patient or Patient's Representative Signature) (Today's Date)

Representative's relation to patient: ___________________________

REFRACTION and NON-COVERED SERVICES

Medicare and most medical insurances do not consider a routine eye exam or refraction to determine changes in your glasses prescription to be medically necessary and do not cover these services. Refraction is not only necessary to prescribe glasses and contacts, but also assists in determining and assessing the ocular health of the eye or need for surgical procedures. **You are expected to pay for these services as well as any balance due because of applicable deductibles, co-insurances, co-pays, other non-covered services, authorization not obtained prior to visit, doctor not on insurance plan, or incorrect insurance information. I have read the above statement and understand refraction is a non-covered service for Medicare and medical insurances. The co-pay is separate from and not included in the refraction fee or contact lens evaluation and fitting fee.**

PATIENT'S SIGNATURE OR GUARDIAN ____
Date

DILATION

Our doctors feel dilation is a necessary part of an eye exam to determine complete ocular health. You will be dilated as part of your annual eye examination. If for some reason you are not able to be dilated, you will have 30 days to return for dilation at no extra charge. **Any appointment for dilation after 30 days of your original exam will be charged a minimum of $30.**