CLEARVISION OPTOMETRY
MEMBER VISION SOURCE NETWORK

Authorization and Financial Information

Patient: (Please Print)_____ SSN (Last 4 digits) __ __ __ __ DOB_____

It is our sincere desire to provide the best possible eye care. This involves a mutual understanding between patients, doctors, and staff. We encourage you, our patient, to discuss any questions you may have regarding our payment policy. Everyone benefits when definitive financial arrangements have been made. Our professional services are rendered to you, not the insurance company. Therefore, payment for services is ***your responsibility.*** We gladly accept most forms of payment including: Cash, Check, Money Order, Credit Card, American Express and CareCredit.

PLEASE READ AND SIGN THE FOLLOWING:

1) I authorize this office to release any information regarding my care to expedite claims or for records transfer should that be requested. I understand that if records are requested a fee will be charged according to the Virginia Freedom of Information Act regarding records release and transfer fees.

2) I hereby authorize this office to bill my medical insurance company for services provided, with payment to be made directly to the physician optometrist. Pre-paid vision plans will be billed secondarily.

3) In the event I receive payment from my insurance company for services rendered in this office; I agree to endorse payment received to the physician optometrist or this office.

4) I understand and agree that I am directly and fully responsible to the physician optometrist for payment of all charges. I understand that such payment is not contingent on any settlement, judgment, insurance decision, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 40 days, it is my responsibility to pay the doctor's bill and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.

5) I understand that any overpayment will be credited to my account and/or forwarded to me, at my request.

6) I understand that Medicare specifically does not cover the refraction part of the eye examination and I am responsible for that fee today.

7) I understand that contact lens services are not considered medically necessary and are usually not covered by insurance. I am responsible for any contact lens fitting fees, prescription renewal fees and/or lesson fees.

8) I understand that there will be a $50.00 charge on all returned checks.

9) I understand that any portion not covered by my insurance company for custom made/ordered product from this establishment will be paid for in full. If the balance amount for the product is not paid, I will forfeit any deposit made by me or my insurance company, and this establishment will retain the deposit as damages.

I understand and agree to the above

Signature: _____ Date:_____
(Guardian if under 18 years of age)

Witness: _____ Date:_____

A photocopy of this authorization and understanding shall be considered as valid as the original.

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HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____