AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of Wadzinski Eye Clinic to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Please list anyone who you may allow us to speak with regarding your appointments, bills and/or insurance claims, your medications, your medical condition, or any medical problems you might have.

Name and relationship of person(s) who you wish to allow access: (spouse, child, sibling, caretaker, friend)

Name of Person or Entity: **Relationship:**

_____

_____

_____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

Signature:_____ Date:_____

INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright light bothersome. It is not possible for your doctor to predict how much your vision will be affected by dilating drops/ Because driving may be difficult after the administration of dilating drops, it is best if you make arrangements not to drive yourself. Wadzinski Eye Clinic is not responsible for incidents or accidents related to dilation.

I hereby authorize Wadzinski Eye Clinic to administer dilating eye drops. The eye drops are necessary to diagnose my condition. I understand that this consent is valid until I request a change in my consent and sign a new form.

Signature:_____ Date:_____

PATIENT INFORMATION

Name: _____ Today's Date: _____

(Last) (First) (Middle)

Marital Status: (Circle One) Single / Married / Widow / Divorced / Separated Sex: ___ Male ___Female

Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____

City_____STATE_____ZIP_____ Home Phone: (____)_____

Employer:_____ Business Phone: (____)_____

Cell Phone: (____)_____I agree to receive an invitation via cell phone for a review Y N

IDENTIFYING INFORMATION

Preferred Language: Arabic Cantonese Chinese English French German Greek Japanese
(Circle One) Korean Mandarin Portuguese Russian Spanish Tagalog Italian Vietnamese

Race: American Indian or Alaskan Native Asian Black/African American
(Circle One) Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic/Latino Not Hispanic/Latino
(Circle One)

SPOUSE INFORMATION (OR PARENT INFORMATION IF PATIENT IS A MINOR CHILD)

Name of Spouse/Parent: _____ Employer: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

PHYSICIAN INFORMATON

The doctor who referred me here today:_____City:_____

My Family Doctor:_____City:_____

My Regular Eye Doctor:_____City:_____

EMERGENCY CONTACT

Who shall we contact if we need to reach you and are unable to do so at the numbers or address listed above?

Name: _____ Phone: _____

Relationship: _____

Refraction Payment Policy
A refraction is performed as part of a normal eye examination. It is a test that determines the best vision possible and provides a prescription for glasses if needed. It is also needed to determine if any medical, optical or surgical treatment may be indicated. It is a necessary part of an ophthalmic examination, but it is NOT a covered service by Medicare and most insurance companies. **Our fee for the refraction is $40.00, and this fee is collected on the day of your appointment in addition to any co-payment, co-insurance, or deductible.**

Contact Lens Evaluation Policy
Your contact lenses are a medical device and have a limited life span. Proper care is essential for successful wear and good eye health. A contact lens evaluation is a required service every year and is NOT a covered service by insurance companies. **The fee for your contact lens evaluation is $55.00 which includes follow-up appointments related to your contact lenses for 30 days. This fee is collected on the day of your appointment.** Additional fees will be charged for visits not related to contact lens fit and/or for changing the contact lens brand or color. **If you do not return for your follow-up visit within the 30 days, your contact lens prescription will not be finalized and you will be required to pay an additional $55 contact lens evaluation.**

Routine Vision Exam Policy
Wadzinski Eye Clinic does not accept or participate with any vision insurance plans. We are happy to provide you with a copy of your services at each visit so you may file your insurance claim to your vision insurance company. **For routine (non-medical) eye exams and contact lens exams, you are responsible for paying for your exam and your refraction (as mentioned above) on the date of your exam.** You may request that we submit the charges for your exam to your medical insurance under your Wellness benefits (not your vision insurance). Wadzinski will offer a discounted rate for patients that do not have a wellness plan coverage with their medical insurance plan or vision insurance which will be due at time of service.

Medical Exam Policy
Wadzinski Eye Clinic will bill your medical insurance for any medical appointment. You are responsible for your co-pay, co-insurance, and deductible on the date of service.

ACKNOWLEDGEMENT

I have read the information above and understand that refraction may be a non-covered service. **I agree to pay $40.00 for my refraction and at any future appointment where a refraction is needed.**

I have read the information above and understand that my insurance will not cover contact lens evaluations. **I agree to pay $55.00 for my contact lens evaluation.**

Additionally, I understand that Wadzinski Eye Clinic will not send any charges to my vision plan. **I agree to pay for my routine vision exam today and at all future routine vision exams.** If I request, Wadzinski Eye Clinic will bill my *medical* insurance for my routine eye exam and refraction. If I receive the discounted rate, the service will not be submitted to your medical insurance, and charges may not be accepted by vision plans.

I understand that for medical eye exams, I will pay an insurance co-payment, co-insurance, and deductible for services I receive at Wadzinski Eye Clinic and that these payments are due at the time of my appointments.

I will contact the front desk to reschedule my appointment if I am unable to pay today or at any future appointments.

Signature: _____
(Patient or Guardian)

Printed Name: _____ Today's Date: _____

PATIENT FINANCIAL POLICY

INSURANCE: Your insurance policy is a contract between you and your insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, any unpaid charges are your responsibility. You are expected to know and to follow all of the regulations as agreed to by you and your insurance company regarding referrals, second opinions, or pre-certifications. Any out of pocket expenses such as co-pays, co-insurance, refraction, and deductible must be paid at the time of service. Failure to provide copies of insurance cards and photo identification may result in denial of your claim, and you will be held responsible for your balance.

CO-PAYS: In accordance with your insurance contract, your specialist co-pay is due at the time of service.

SERVICES RENDERED TO A MINOR OR DEPENDENT PERSON: We will look to the adult accompanying the patient for payment on the date of service. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply the subscriber's name, address, phone, date of birth, and social security number. We request that you inform the subscriber that his or her insurance has been used.

NO INSURANCE: Payment in full is due at the time of service.

METHODS OF PAYMENT: We accept cash, check, Visa, MasterCard, Discover and payment plans from Care Credit (subject to credit approval).

NSF CHECKS: Any check that does not clear your bank account will result in a $30.00 fee.

REFUNDS: If an overpayment has been made, a refund check will be issued. Overpayments of $5.00 or less will be credited to your account.

STATEMENTS: If there is a balance on your account after filing to your insurance carrier, you will receive a statement. Payment is expected within 30 days from the date on the statement. If you have questions regarding your statement, please contact our billing department immediately. Your account will be considered delinquent after 30 days from your first statement. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency during the collection of your owed amount.

PARTY RESPONSIBLE FOR PAYMENT

I have no medical coverage. I understand I am responsible for payment as services are rendered.

I have my own insurance. I will provide my insurance card at check-in at each appointment. I understand that I am responsible for all co-pays, co-insurance, and deductibles in accordance with my insurance policy.

I have another family member who carries insurance under which I am covered. I understand that I am responsible for all co-pays, co-insurance, and deductibles in accordance with this insurance policy. Please list policy holder below:

This is a Workmans' Compensation visit due to an injury I sustained on the job.

I have read and understand the financial policy of Wadzinski Eye Clinic regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulations, policies, and procedures.

Signature:_____ Date:_____