Sight Eyecare

EMERGENCY CONTACT INFORMATION & CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ , grant permission for the person(s) listed below to have access to any and all of my medical information pertaining to my care from the physicians of this clinic. This includes, but is not limited to, appointment times, my physician's plan for my ocular health and all prescriptions, accounting information, etc. In the event of an emergency, please list the names of the individuals you would like us to attempt to contact. If your emergency contact and consent for release of medical information are not the same, please make our staff aware of the changes.

Signature _____ Date _____

Name _____ Telephone #_____ Relationship _____

Name _____ Telephone #_____ Relationship _____

DILATING YOUR EYES

Dilated eye exams allow for a much more detailed view of the retina (the interior of your eye) and make possible the diagnosis of tumors, vascular problems, retinal holes, and tears. With dilation most patients experience some degree of blurred vision, which can affect driving and reading. These effects may last five to six hours after the dilating drops are instilled. Because your safety is of utmost importance to us, we prefer that you have someone with you to drive you home. **Dilating is included in the price of the exam at no extra charge**. If you cannot do it on the day of your exam, you do have up to six weeks to return for your dilation.

WOULD YOU LIKE TO HAVE YOUR EYES DILATED TODAY?

_____**YES**, I would like to have my eyes dilated _____**NO**, I do not want my eyes dilated

_____I would like to dilate at another time _____I would like more information

Signature _____ Date _____

DIGITAL RETINAL PHOTOGRAPHY

Digital retinal photography allows us to capture a picture of the back of each eye, providing us with an excellent baseline to monitor your current and future eye health. **We strongly recommend this procedure every year to better help us monitor you eye health.** Retinal Photography assists our doctors in the early detection of many problems such as diabetic retinopathy, hypertensive retinopathy, macular degeneration, glaucoma, retinal detachments, and other vision threatening conditions.

The fee for this additional part of your eye exam is $35. Retinal photos are not covered under most vision plans. However, depending upon your diagnosis, this may be covered by medical insurance.

_____**YES**, I want to have retinal photos taken of my eye for documentation

_____**NO**, I do not want to have this procedure done today

Signature _____ Date _____

CONTACT LENS EVALUATION & FIT FEE

The contact lens evaluation/fit is never considered part of a routine eye examination. The evaluation/fit is used to monitor any changes that the eyes have undergone in the past year from wearing contact lenses. This evaluation/fit is ensuring that you have the most optimal fit possible while wearing your contact lenses. The fee includes follow-up visits directly related to contact lens wear within a 90-day period. This fee may or may not be covered by your insurance plan. According to FTC regulations, you will receive a copy of your contact lens prescription after it is finalized by the doctor.

Signature _____ Date _____

Sight Eyecare

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Sight Eyecare/Dr. Laura H. Sechler for any covered services furnished to me. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services (CMS – Formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for related services. Medicare is your primary health insurance and for your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits, tests, and covered materials. Medicare then reviews all submitted claims and if approved reimburses our office 80% of the approved amount. The remaining 20% (co-payment) and/or deductible amount is your responsibility as the Medicare beneficiary. You may also be responsible for certain non-covered, non-medically necessary fees. Our office may elect to 1) bill you directly for your portion of the fees, or 2) bill your supplemental insurance if you carry it.

Do you carry supplemental insurance? (circle one) **YES** **NO**

Carrier Name _____ Policy Number _____

Signature _____ Date _____

NON-MEDICARE PATIENTS

I authorize the release of all medical information necessary to process this claim that is pertinent to my medical care. I assign all vision, medical and/or post-operative surgical benefits, including major medical benefits, to which I am entitled to Sight Eyecare/Sechler Family Vision, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I will be financially responsible for non-covered services and charges.

Signature _____ Date _____

PATIENT PAYMENT RESPONSIBILITY

If you do not inform us that you have a vision plan or medical insurance before services are rendered, we must assume no coverage exits. **Please provide our office with your current insurance information before arriving to your appointment. We will gladly file your vision/medical insurance claim as a courtesy to you.** We have no control over your contract with your insurance company. Because insurance policies vary greatly, we can only estimate coverage in good faith. **We at no time guarantee what your insurance will and will not cover.** I agree this office will not back-file claims or refund fees after services are rendered due to lack of notification of vision or medical benefits (with no exceptions). I understand that I am financially responsible today for all fees. I agree that I am financially responsible for any and all fees not collected in full for the date of service or should my insurance plan deny payment or apply it to my deductible for services or materials rendered.

I authorize the release of all medical information necessary to process this claim and that it is pertinent to my medical care. I assign all vision, medical, and/or post-op surgical benefits including major medical benefits to which I am entitled to Sight Eyecare/Sechler Family Vision, PLLC. This assignment is considered as valid as the original. I understand I will be financially responsible for non-covered service and charges.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY POLICY & PRACTICES

I understand that to protect the privacy of my identifiable health information, Sight Eyecare/Sechler Family Vision, PLLC, has established a Privacy Policy and guidelines for Privacy Practices within their office. This information explains the use and/or disclosure of information contained in my personal records kept for the purpose of diagnosis, treatment, payment, and health care operations. In accordance with HIPPA regulations, a copy of the Privacy Policy & Practices of Sight Eyecare/Sechler Family Vision, PLLC has been made available to me while in the office today. A copy will be provided to me upon request at no charge.

Signature _____ Date _____