Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Access Eye for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ Initial

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Access Eye for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance carrier. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me, unless I request a restriction in writing. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that it is my responsibility to obtain a referral if it is required by my insurance company. I will be responsible for all charges if am seen without a referral.

_____ Initial

Payment Information:

All payments are due at the time of service, and in some instances, prior to an appointment or procedure. If the account has to be turned over to an attorney/collection agency, the undersigned agrees to pay all cost of collections, including attorney fees, interest, and court costs. This form will be placed in my chart and be applicable until such information is changed. There is a $50.00 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours' notice. There is a $150 charge for failure to show up for a surgical procedure or cancel with less than 7 days' notice.

_____ Initial

Appointment Reminders

We send courtesy reminders prior to appointments that can be in the form of calls, texts or emails. If for any reason you do not receive your reminder, this does not negate the no show policy. It is ultimately your responsibility to remember your appointment day and time. Failure to confirm through the remindersdoes not cancel your appointment. To cancel, please inform us by calling our main number, or sending an email prior to 24 hours of your scheduled appointment to avoid a missed appointment fee.

_____ Initial

Use and Disclosure of Protected Health Information:

I understand that Access Eye may use and disclose my protected health information for purposes of treatment, payment, and health care operations, including electronically. I also acknowledge that I have received, have been offered, or have received in the past, a copy of the Access Eye Notice of Privacy Practices, which provides information about how the Access Eye, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer, at (540) 371-2020. I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment, or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

_____ Initial

Please Complete Reverse ➔

I authorize my Protected Health Information can be discussed with:

1. _____ Expiration Date: _____

2. _____ Expiration Date: _____

I restrict my Protected Health Information from being discussed with:

1. _____ Expiration Date: _____

2. _____ Expiration Date: _____

This form does not authorize the release of healthcare records to any of the above-mentioned individuals. I understand that I can change this authorization or restriction for my Protected Health Information in writing at any time.

Refraction Policy:

A refraction is the process of determining if there is a need for corrective glasses or contact lenses. It is an essential part of any eye exam and necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, **DO NOT COVER** refractions or routine eye exams. Medicare allows that we charge separately for that portion of the exam, since it is not a covered service. If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know. If you have any questions regarding our policy, please do not hesitate to ask. You will be refracted and charged the fee if any of the following occurs:

1. If you want new glasses and or contacts.
2. If your vision has dropped more than 2 lines from the previous visit.
3. If you complain of any vision changes.

_____ Initial

I have read, initialed, and understood the above information.

Signature: _____ Date: _____
Patient or Legal Surrogate Relationship to Patient

Witness: _____ Date: _____