48 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Eye Life Vision Center reserves the right to charge a fee of $50.00 for all missed appointments (“no shows”) or appointments canceled within 48 hour from their schedule time. Some practices will over book the schedule in anticipation for no-shows. However, this can result in patients having to stay longer than anticipated. We strive to get patients in on their scheduled time because we understand time is valuable to everyone.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “no shows” in any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Signed Name **Date**

_____

Printed Name

Communications Request

In order for us to communicate with you via text or email we first need your permission. These communications include appointment reminders, general communications, offers and occasional surveys. We will NOT sell your information to anyone at any time.

Please choose one or both:

[ ] Text [ ] Email

Printed Name: _____

Sign: _____

[ ] I certify that I am providing my own contact information. By participating, I consent to receive future emails, text messages and/or calls from Eye Life Vision Center which may be sent through automatic email and telephone dialing systems.

Routine Eye Exams vs. Medical Eye Exams

Please read and sign prior to examination

Annual eye exams are important to maintaining the health of your eye. Insurance benefits may vary depending on the nature of your visit and the symptoms you may be experiencing. It is your responsibility to know and understand coverage provided by your insurance plan.

Your exam will be coded medically if you report any symptoms and/or eye problems, or are being evaluated/treated for a medical condition. In the case that the doctor discovers a condition during the exam, your visit will be billed to your medical insurance and will be subject to co-pays and deductibles according to your plan.

An eye exam is considered routine if you do not report any symptoms and/or medical eye conditions prior or during your visit, and pending the doctor does not discover any conditions. During a routine eye exam your eyeglasses and contact lens prescription is updated, and a basic health screening is performed to assure the health of the eye is maintained. If you report any symptoms during your examination, it is the practice's responsibility to bill accordingly based on the guidelines set by your insurance plan. Please note: not all medical insurance plans cover refractions, therefore you may be responsible for the charge associated with this portion of your visit.

Please be aware that your exam will be submitted to your insurance not only based on what you report during your visit, but also depending on what the doctor finds during the exam. Vision plans do not cover medical visits, and not all medical insurance plans cover routine exams. If you have any questions about your coverage, please ask a member of our staff.

PAYMENTS ARE DUE AT TIME OF SERVICE.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Submitting claims to insurance companies.
- The day-to-day healthcare operations of this practice
- Coordinate with other healthcare practitioner to best manage the care of the patient.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I give Eye Life Vision Center permission to disclose and discuss the results of my eye exams and pertinent findings with the following people:

_____

_____

_____

Print Patient Name _____

Signature _____ Date _____
(Parent/guardian if patient is a minor)