

VISION SOURCE™ at Jordan Landing

Welcome to our office. We appreciate having you as a patient, and look forward to providing health care and customer service that you can be happy with. Please read the following document as it contains important information regarding your privacy, insurance coverage, examination fees, and refund/remake policies. By initialing after each paragraph, you acknowledge that you have read the paragraph and that you agree with and understand the information contained therein.

INSURANCE COVERAGE

The optometrists of Vision Source at Jordan Landing participate as providers on a number of vision plans, including VSP, EyeMed, Superior Vision, and others; which cover the cost of one comprehensive healthy eye exam per year, and normally includes an allowance for glasses or contact lens materials. We also participate on a variety of medical insurance panels such as Blue Cross, PEHP, DMBA, United Healthcare, and others. Medical insurance often provides coverage for one healthy eye exam per year, and also includes coverage for medical eye care, including infections, injuries, allergies; and management for conditions such as cataracts, glaucoma, macular degeneration, and diabetic eye problems. If the purpose of an exam is to obtain a prescription for glasses and/or contact lenses, the exam will be billed as a healthy eye exam. Otherwise, the exam must be billed to medical insurance as an office visit. If further treatment, testing, or follow-up is required, such visits will also be billed to medical insurance. For that reason, all patients are asked to please provide a copy of their medical insurance cards. There are some insurance companies that selectively exclude optometrists from reimbursement. If a patient's insurance company refuses to reimburse for services performed in this office, the patient is ultimately responsible for the charges.

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SPECTACLE POLICY

As a service to our patients, we use only the highest quality frames, spectacle lenses, and coatings. Each frame purchased from Vision Source is protected with a 2-year warranty (**excluding OAKLEY & OVVO frames**), under which a broken frame determined by the manufacturer to be defective can be replaced at no cost to the patient **up to two times**. If your purchased frame is no longer manufactured, we will happily arrange a new frame from the same manufacturer if you desire, but we will require new lenses to be purchased with a 50% discount. We cannot take any responsibility in any form for frames not purchased from our office. **Lenses protected with premium protective coatings (anti-scratch or anti-reflective) are also warranted for two replacements within two years** against normal wear & tear (scuffing/scratching), as determined by the lab (which excludes negligent damage – caused by pets, for example). **Warranties do not cover loss, nor do they cover scratched lenses on sunglass lenses or sun clips (unless a separate anti-scratch treatment is paid for and applied).** It is not possible to cancel an order or switch a frame after the job has been sent to the lab and cash refunds are not offered. At the doctor's discretion, patients who are not satisfied with the vision in their new glasses may have their prescription checked and lenses remade **one time** into the original frame at no cost within 90 days of the date on which the order was placed. A second visit to check the prescription within 90 days, or any visit subsequent to the 90-day window will be subject to a \$45 fee. Any remake beyond the one-time doctor-redo will be done at a 50% discount to the patient. Patients unable to adjust to new progressive lenses (no-line bifocals) may have their lenses remade into a traditional bifocal or trifocal design, although the progressive upgrade fee is non-refundable. Payment is due for all spectacle orders at the time the order is placed, including lens options not covered by insurance (such as transitions, anti-reflective coatings, tints, etc.). For those wishing to purchase a second pair please ask staff for current promotions. Prescriptions will include a binocular pupillary distance measurement. Monocular PD measurements or others required for fitting of progressive lenses or bifocals not purchased in this office are also subject to the \$45 fee. Frames not purchased in this office will not be adjusted without patients signing a release of liability waiver, because we can only replace frames purchased here under warranty. All patients will receive a copy of their prescription per the FTC's "Eyeglass Rule" (1992) unless he or she requests *not* to receive a copy. **If you wear contact lenses, please request a copy of the contact lens agreement.**

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PUPIL DILATION

The purpose of pupil dilation is to examine the health of the internal structures of the eye, including the crystalline lens, the optic nerve, the macula, and the retina. In conjunction with other findings from the comprehensive exam, pupil dilation can aid in the diagnosis of cataracts, glaucoma, macular degeneration, and other retinal disease. The doctors of Vision Source at Jordan Landing recommend pupil dilation for all new patients and periodically thereafter. For patients that have been diagnosed with diabetes or other conditions that may affect the health of the eye, a pupil dilation is recommended at least yearly, or more frequently if indicated.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Vision Health Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- Yes** – I agree to continue my care as I have read, had explained, OR was given the opportunity to me by Vision Health Center, Inc.'s Notice of Privacy Practice with Vision Health Center, Inc. under said terms.
- No** – I do not wish to continue my care as I have read, had explained, OR was given the opportunity to me by Vision Health Center, Inc.'s Notice of Privacy Practice with Vision Health Center, Inc. under said terms.

APPROVAL OF INFORMATION RELEASE

Yes – I grant permission to have my spectacle and/or contact lens prescription(s) emailed to me **when I request it**. I do so with the knowledge that the means by which said prescription(s) will be sent is NOT encrypted and there is a security risk.

Please send glasses and/or contact prescription(s) to the following email when requested: _____

No – I do not grant permission to have my spectacle and/or contact lens prescription(s) emailed to me.

I authorize the following people to have access to my medical and financial information, unless I specify particulars otherwise. Meaning that the doctors and staff at Vision Source at Jordan Landing can discuss medical conditions, treatments, insurance coverage, and fees/payments with the following:

(Name) _____ (Relation) _____

(Name) _____ (Relation) _____

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- I understand that the fees for professional services are due when services are rendered. If I am unable to make payment at this time, a 15% service charge will be added to my account. Any exceptions will be made only by specific arrangements before services are rendered.
 - I understand that I am responsible for payment of this account regardless of insurance company action. I accept that Vision Health Center will attempt to bill my insurance company and/or vision plan for 90 days, after which – if there is no response from or payment made by my insurance or plan – financial responsibility will return to me at which time I must pay in full, then seek reimbursement on my own from my insurance or plan.
 - I understand that there will be a \$20.00 returned check charge, and agree to pay all cost of collections, including 1/3 of any outstanding balance collection fee (up to 40%), plus attorney fee, if necessary, to collect any debt.
 - Patients who provide a mobile phone number authorize our office to communicate via text message for healthcare-related purposes, including appointment reminders and office notifications. We will not share mobile numbers to a third party.
 - I understand that my signature below verifies that I understand the information provided on this document, as well as serves as a "Signature on File", in accordance with HIPAA regulations.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name (Please Print) _____

Signed: _____ **Date** _____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative

Relationship to Patient