Acuity Eyecare LLC Patient Consent Form

Consent for Treatment: I do hereby voluntarily consent to examination and to the rendering of such care and medical treatment as may be deemed necessary or appropriate by the physicians and other clinical personnel of the practice.

Release of Information: I authorize the practice to use or disclose my health information (1) for treatment purposes, (2) in connection with payment or reimbursement for health services or materials provided to me, or (3) for the purpose of carrying out Practice operations. Such disclosure may be made to any person, company or agency which is or may be responsible for all or part of charges for my treatment and/or examination- including but not limited to insurance companies, medical service companies, managed care organizations, worker's compensation carriers, peer review organizations, government agencies or other responsible parties, all or part of my medical information or records in connection with payment for or establishing the medical necessity of my admission or treatment, or as otherwise required by law. I ALSO AUTHORIZE THE RELEASE OF SUCH INFORMATION TO OTHER TREATING OR CONSULTING PHYSICIAN(S) AS WHO MAY BE INVOLVED IN MY CARE. (In connection with the use of disclosures of my medical information, I acknowledge the Practice has offered me a copy of Privacy Practices for review and to keep for my records on the date identified below.) I can be assured that Acuity Eyecare,LLC does not sell my personal health information of any kind to a third party for such party's own use, regarding the vision services and products that I have received from Acuity Eyecare,LLC.

Financial Responsibility: In order to control the cost of billing, the patient's portion of the bill is paid at the time service. These fees are confirmed by your insurance company prior to the appointment. Your insurance company informs of deductibles, co-payments, co-insurance, material fees and noncovered services that are your responsibility and expected to be paid on the day of appointment. Accounts 60 days old are subject to collection fees.

I understand that any check for services returned for any reason will result in a fee of $45 which will be added to my account.

All HMO insurances require a referral for services from a valid PCP registered with my insurance. I UNDERSTAND IF A VALID REFERRAL FOR SERVICES FROM MY PRIMARY CARE PHYSICIAN IS NOT ACQUIRED BY ME BEFORE MY APPOINTMENT, I WILL BE RESPONSIBLE FOR ALL CHARGES AND FEES RESULTING FROM THE VISIT.

Vision Insurance (such as VSP, Eyemed, and Spectera): Vision insurance only applies to routine eye exams along with eyeglasses and contact lenses. Vision plans only cover basic screenings for eye disease, VISION PLANS DO NOT COVER DIAGNOSIS, MANAGEMENT, OR TREATMENT OF EYE DISEASE.

Medicare Advantage Plans. Not all plans have COB(Coordination of Benefits) with your selected vision plan program. If you have pre-existing medical history or previous history of medical eye surgery, your exam will be considered medical. If your selected vision plan has no COB then a second separate appointment can be utilized for an eyewear exam after the eye health appointment is completed.

Medical Insurance (such as Blue Cross/Blue Shield, Harvard Pilgrim, Medicare etc.): Medical Insurance must be used if I have any eye health problems or systemic health problems that have ocular complications. My Doctor will determine if these conditions apply to me, however, it may also be determined by my case history. The test(s) needed to determine my refractive error (necessary for eyeglass prescriptions) IS NOT COVERED BY MEDICARE and MOST FEDERAL INSURANCE if insurance does not cover the service the fee for service will be paid by the patient on day of examination.

Diabetic Care is coordinated managed by your Medical insurance. The exam will be billed to the medical insurance only. Vision plan may be utilized for contact lens services and for purchase of eyewear. Retinal Coherence Tomography is part of comprehensive diabetic eyecare. If not covered by the medical plan a fee of $39 will be paid on the day of examination.

Consent: I have read the information provided in this form (or had such information read to me) carefully and in its entirety, have been given an opportunity to ask questions and have received satisfactory answers to my questions, if any. I understand the content of this form and agree to the terms contained herein. I certify that all information supplied by me as part of the registration process is correct.

_____ _____

Signature of Patient Date

For any patient who is incapable of providing informed consent to medical treatment or assuming financial responsibility for payment of medical services, a legal representative of the patient must complete the following and sign on behalf of the patient.

The Patient is incapable of providing consent because (check one):
_____ The Patient is a minor who is _____ years of age.
_____ The Patient's mental or physical condition prevents him or her from being able to sign this form.

By my signature below, I certify I am authorized by law to provide consent on behalf of the Patient.

_____Patient / Patient Representative Date_____

_____ Realtionship to Patient