THE FOLLOWING INFORMATION MUST BE REVIEWED BY EACH PATIENT OR GUARDIAN, IF PATIENT IS UNDER 18 YEARS OF AGE

____ I authorize the doctor and staff to administer treatment as reasonable or necessary, in connection with conditions that I or members of my family have sought care for.

____ I authorize the doctor and staff to disclose my health information to any health care provider for the purpose of rendering treatment to me.

____ I authorize the doctors and staff to disclose my health information to my health insurance company for the purpose of payment.

____ I understand a fee of $20 will be in addition to my regular copay for an Optomap Image. This mandatory image is part of your comprehensive eye exam. It provides our doctors with a thorough view of your retina and can detect a presence of disease or confirm a healthy eye.

IF PATIENT WILL BE FIT FOR CONTACT LENSES

____ I understand that the contact lens service fee is a **non-refundable** charge, whether the fit is successful or not.

____ I understand that the contact lens service fee includes up to three contact lens follow-up visits (if needed) **within three months** of the initial contact lens consultation.

____ I understand that the prescribing doctor will release my contact lens prescription once I have returned for all necessary follow-up appointments. The contact lens prescription will be valid for one year from the date of the original examination.

____ I understand that the contact lens service fee does not include services provided to treat eye infections, abrasions, trauma or any other medical condition incurred while using contact lenses, whether they can be attributed to actual contact lens use or not. Treatment of other medical conditions will be billed to my medical insurance, when applicable. If I do not have any medical insurance I will be responsible for the charges incurred.

HIPAA ACKNOWLEDGEMENT

____ I acknowledge that a copy of the HIPAA privacy policy is available to me upon request.

I have read and understand the policies above. _____

Signature of patient or guardian

_____

Date