

Spyglass Qrdm

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We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

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Patient Information

Name:
Address: , , {PATIENT_STATEORPROVINCE},
Tel : (home) : SSN: -- D.O.B :
(work) : (cell) :

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Responsible Party Information

same as above

Name:
Address:
Tel : (home) : SSN: D.O.B :
(work) : (cell) :

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Primary Insurance Information

Insurance company :
Policy number :
Group number :
Insured:

Secondary Insurance Information

Insurance company :
Policy number :
Group number :
Insured:

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RETINAL PHOTOS

A new, highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of your eyes. The digital retinal imaging system takes images of the retina (the back part of your eye). This procedure assists your doctor in the early detection and follow-up care of many disorders, including glaucoma, diabetic eye disease, macular degeneration and other vision threatening conditions. The images will be stored in the computer and compared with the images at future examinations. This allows our doctors to observe even the smallest amount of change from the previous examination.

Dr Young recommends that *all* patients have this procedure performed. It is *especially* important for patients with:

- Glaucoma or a family history of glaucoma
 - Diabetes or a family history of diabetes
 - Hypertension or a family history of hypertension
 - Macular degeneration or a history of macular degeneration
 - High myopia (nearsightedness)
 - History of any retinal disease or disorder
- =====

There is an additional charge of **\$24** for this procedure, which may not be reimbursable through your insurance. Please check the appropriate line below and sign at the bottom:

_____ I **Do** want the procedure performed.
_____ I **Do Not** want the procedure performed. ***Please note that during your examination, the doctor may discover findings that may require that this procedure be ordered.***

If you are unsure about this procedure or have any concerns, please feel free to ask Dr Young during the exam and he will be happy to answer any questions you may have. Thank you.

Signature _____ Date _____

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Please continue to read the following carefully and sign on the designated lines below. Thank you!

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AUTHORIZATION TO RELEASE INFORMATION: I/ WE hereby authorize Spyglass Vision Clinic to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Workers Compensation.

CONSENT FOR TREATMENT: I/WE hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, co pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature : _____ **date** _____

Acknowledgement of Receipt of this Notice:

This Practice is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

Medical Insurance Policy:

As part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

- 1) The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
- 2) When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances.
- 3) Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's.
- 4) Unpaid balances are the sole responsibility of the patient.
- 5) To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
- 6) I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
- 7) I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

Refund/ Return Policies:

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time the refund is issued. Opened boxes of contact lenses are non-refundable. After the 30 days period, only 50% of the original payment made by the patient (private-pay or with vision medical insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, no exchange, no return can be made on any goods purchased at this clinic.

I acknowledge that I have received the Notice of Privacy Practices for Spyglass Optik and understand and agree to the above policies.

Signature of patient or authorized representative

date