Specs Eye Care
Consent for Testing and Dilation

Patient's Name_____ Date_____

At Specs Eye Care, we pride ourselves on investing in new technology to provide the best possible patient care. Our doctors now recommend the Optomap® Retinal Exam on **ALL** patients and Wellness OCT on all patients over 30. These quick, non-invasive procedures enhance your eye exam and allow the doctor to see a much broader and more detailed view of the retina compared to undilated (and in some cases, dilated) examinations. The scans become a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions present at a future examination. **Dr. Roland and Dr. Spencer strongly believe that the Wellness OCT and Optomap® are essential parts of your comprehensive eye exam and prescribes it for all patients once per year.**

The fee for these scans is $64 ($44 for Optomap and $20 for Wellness OCT) and is **not** covered by your vision care plan or health care plan unless they reveal a problem with the health of your retina. If a health problem exists, your medical insurance will be filed as a courtesy for the testing.

***Without either the Optomap or dilation of the pupils, your eye doctor may be unable to detect some health problems such as glaucoma, cataracts, retinal detachments or tears, diabetes, high blood pressure and some tumors. The only way to have a complete and thorough eye exam is to get a good look at the retinas.**

Please <u>INITIAL</u>:

_____ I prefer to have the Optomap® Retinal Screening Exam.* In some instances, the doctor may need to perform a dilated fundus exam in addition to the scans. I understand that there is an **additional copayment for the tests**. In some cases, we may be able to file your **vision** or **medical insurance** for your photos.

_____ I prefer to have my eyes dilated today. I understand the risks/potential **side effects** of the dilation, including **blurry vision and light sensitivity**. I have a driver with me or will arrange for one at the conclusion of the exam if I feel I am unable to drive safely. A dilated fundus exam is included with the comprehensive eye exam at no additional charge.

Patient's/Guardian's Signature: _____Date:_____

Specs Eye Care
PAYMENT & INSURANCE POLICY, CONSENT & HIPAA

Patient Name: _____ Date:_____

Current Address: _____

PAYMENT POLICY/ASSIGNMENT OF BENEFITS to FILE INSURANCE/RELEASE OF INFORMATION:

*I hereby authorize payment directly to SPECS Eye Care. All Self-Pay or Insurance Co-Pay, including non-covered services, are due at the time of service. I understand that I am responsible for all charges not covered by my insurance. Self-Pay discount is not allowed for services billed to my insurance carrier. I hereby authorize release of all information necessary to pay my claim. There is a **$50** insufficient funds fee for all returned checks. There will be additional fees for any past due balances that are transferred to a collection agency.

Insured/Parent/Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

*I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Insured/Parent/Guardian Signature: _____ Date: _____

*Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? (Circle one) YES NO Name of person:_____

ROUTINE VISION PLAN vs. MEDICAL INSURANCE

There are **two types** of health insurance that will help pay for your eye health services and products. You may have both types and Specs Eye Care accepts most vision care plans and insurance plans in both categories: (1) **Routine** Vision plans (such as VSP, EyeMed & Spectera) and (2) **Medical** insurance (such as Blue Cross/Blue Shield, United Health Care, Medicare and others).

- Vision Plans cover **ONLY** routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Routine Vision plans do **NOT** provide for MEDICAL EYE HEALTH CARE NEEDS (such as diabetes, dry eye disease, infections, floaters, etc)

- Medical Insurance **MUST** be submitted for any medical eye healthcare diagnoses and treatment care and follow-up per national billing guidelines

- If you have both Routine Vision Care benefits and Medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.

- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your routine vision plan provider and medical insurance card(s) and identification, for your benefit, to our staff so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

By signing below, I acknowledge that I fully understand the difference between Routine vs. Medical Insurance:

Insured/Parent/Guardian Signature: _____ Date: _____

Contact Lens Agreement for Specs Eye Care

A contact lens prescription requires a separate evaluation than your routine eye exam in order to determine if you are able or can continue to safely wear contact lenses. It is our policy that all contact lens patients have a routine eye exam and contact lens evaluation yearly to check their ocular health and verify the contact lens prescription (which expires after one year by Georgia law). The contact lens evaluation includes the following:

*Corneal health assessment for contact lens wear, measurement of corneal curvature, evaluation of prescription for contact lenses, assessment of fit of contact lenses, insertion and removal training, proper care & education training and two follow up visits relating to the contact lens fit for up to **30 days** from the initial visit.*

During your follow up visit(s), some modification may be necessary. If so, we will dispense/order additional contact lens trials at no additional charge to you before finalizing your contact lens prescription (some lenses are special-ordered and **must** be ordered through our office in case any returns/modifications are necessary). **After the prescription is finalized by the doctor, you will be entitled to a copy of your prescription and will be able to order your supply of lenses.**

The contact lens evaluation fee does not include the cost of the lenses.

Refund Policy: Most patients are able to wear contact lenses successfully, but a successful fit and wearing experience cannot be guaranteed. If you discontinue contact lens wear for any reason during the initial 30 day period, you will be entitled to a refund on the cost of any special ordered lenses (provided that the lenses are returned in wearable condition and are covered under the manufacturer's warranty policy) minus a restocking fee. **The contact lens evaluation fee will not be refunded.**

As with any drug or device, the use of contact lenses is not without risk. A small, but significant percentage of individuals wearing daily wear lenses develop potentially serious complications which can lead to permanent eye damage. This risk increases dramatically for patients who sleep in their contact lenses (extended wear) or fail to practice proper hygiene/handling techniques.

IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS, REMOVE YOUR CONTACT LENSES AND MAKE ARRANGEMENTS TO SEE DR. ROLAND, DR. SPENCER OR ANOTHER EYE CARE PROVIDER ASAP: unexplained eye pain/discomfort, redness, watering/discharge, cloudy/foggy vision, sudden vision change, or light sensitivity.

Contact Lens Evaluation Fees: (price depends on the complexity of fit and is determined by doctor)

Spherical	$50-$70
Toric/Monovision	$65-$85
Multifocal	$80-$100
RGP	$95-$115
Keratoconus/Specialty Fit for Medical Reason	$300/eye, then bill your medical insurance for follow-up visits
Myopia Management Program	$200

I have read and understand the above information and choose to have a contact lens fitting and evaluation today.

_____ _____

Signature of Patient (Guardian if under 18) Print Patient's name

Date_____