NAME (Please print):_____ DATE: ____/____/_____

This notice applies to the following family members: _____

PRIVACY POLICY:

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain insurance payment on your behalf for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail. I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Topa Topa Optometry, Inc.

Signature _____

FINANCIAL DISCLAIMERS:

Eligibility for medical insurance and/or routine vision benefits:

We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only and is not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility.

_____
Initials

Financial Responsibility:

I understand that account balances and co-payments are due at the time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Topa Topa Optometry, Inc. I also authorize Topa Topa Optometry, Inc to release any information required for payment to be made.

If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balance. This includes fees for special testing such as photography, visual fields and OCT. My signature below verifies that I understand this agreement and the above financial disclaimers.

Signature _____

CONTACT LENS FEES: check if you DO NOT wear contact lenses ☐

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient.

Fees for contact lens evaluation services range between $42.00-$215. As with glasses, contact lens materials are an additional fee. My signature below verifies that I understand the contact lens fees.

Signature _____

REFRACTION FEE:

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, Eye-Med, or Medical Eye Services, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction.***

The fee for a refraction is $34.00. My signature below verifies I understand the refraction fee.

Signature _____