Comprehensive

Vision Therapy Center

Infant Child Adult

APPOINTMENT/OPTICAL REMINDERS, HEALTH CARE AND BILLING INFORMATION AUTHORIZATION

Your optometrist and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment or optical reminders, billing information, or health care related information that may be of interest to you. By signing this form, you are giving us authorization to contact you with these reminders and information. This contact may be by way of mail, email, text, or by phone. If this contact is made by phone and you are not home, a message will be left on your voice mail. If the contact phone number you have provided us with is your business phone, a message will be left on your voicemail or our name and phone number only will be left with the receptionist.

You may restrict the individuals or organizations to which your protected health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect the information that we use to contact you to provide appointment or optical reminders, billing information, or any health care related information at any time.

This notice is effective as of **8/1/2003**. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my protected health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____

Print Patient Name Date

_____

Patient / Parent or Guardian Signature Staff Initials

------OVER PLEASE-------

Comprehensive

Vision Therapy Center

Infant Child Adult

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your protected health information.

There are several circumstances in which we may have to use or disclose your protected health care information.

- We may have to disclose your protected health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your protected health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your protected health information within our practice for quality control or other operational purposes.

If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

By signing this form, you are giving our office authorization to release any necessary medical information to process your insurance or Medicare claims, as well as authorizing our office to receive payment of medical benefits for services or supplies provided by Penelope S. Suter, OD. or other doctors under her employ.

Your Right To Limit Uses Or Disclosures

You have the right to request that we do not disclose your protected health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right To Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your protected health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your protected health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____

Print Patient Name Date

_____

Patient / Parent or Guardian Signature Staff Initials

Comprehensive

Vision Therapy Center

Infant Child Adult

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until our staff has verified their respective insurance coverage and deductible.
2. Our office accepts cash, checks, money orders, Visa, MasterCard and Discover. However, we do not accept post-dated checks. There will be a $25 charge for all returned or re-deposited checks. This fee must be paid by cash, money order, or credit card only.

INSURANCE

1. With the exception of Medicare, we are not major medical providers. But as a courtesy to our patients with special needs we will bill your insurance. We accept assignment as a courtesy to you. You are however required to pay 50% of your visit at the time services are rendered. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company. We must have all of your insurance information on the day of your initial visit. Additional insurances will not be accepted after that date.
2. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
3. Our office will resubmit a claim ONE TIME. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor or agent. Any denied or disputed claims will be treated as non-covered services and you will be expected to pay such charges on a timely basis.
4. If you have questions concerning this or any other matter, please speak with the front desk prior to seeing the Doctor.
5. **MEDICARE NOTICE TO BENEFICIARY**: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (10 of the Medicare law. If there is no medical diagnosis resulting from your vision evaluation then Medicare will not pay for the examination and you will be fully responsible.

EYEWEAR DEPARTMENT (OPTICAL)

1. With children, patients with special visual conditions, or special medical conditions, there may be a need for frequent visits. Depending on the condition, the prescription lenses may need to be changed at frequent intervals. These changes are the financial responsibility of the patient.
2. Patients who have difficulty adapting to their eyeglasses after 2 weeks are encouraged to contact our office as soon as possible. If you require bifocal lenses and do not adapt to these lenses within 5 months of consistent wear, you may opt to upgrade to the progressive lens. However, you are financially responsible for the upgraded price difference. If you initially start with the progressive lens and do not adapt within 5 months of consistent wear, you may opt to change your lenses to the lined bifocal. However, you will not be reimbursed for the progressive charge.

CONTACT LENSES

1. If you choose to be fitted with contact lenses and decide to not continue, you are financially responsible for the fitting fee and any follow-ups that you have had. Your insurance, if any, may not cover these services without the purchase of the contact lenses.

Comprehensive

Vision Therapy Center

Infant Child Adult

2. If you wear contact lenses and wish to have them re-evaluated at the time of your examination, there will be a $35 charge for this service that may or may not be covered by your insurance. A $50 fee will be charged if the re-evaluation is done as a separate appointment at a later date. In order for the doctor to update your contact lenses or write a current contact lens prescription for you, this service must be performed.

VISUAL INFORMATION PROCESSING EVALUATION

Please be aware that this service is not generally covered by insurance. If this is testing that you or your child will be undergoing, you will be financially responsible for all charges related to testing.

LETTERS OF MEDICAL NECESSITY/REPORTS

We are happy to provide you with the procedure and billing codes for our services. Please be aware that there will be an additional fee of $45 if our staff needs to provide medical necessity reports or further services in relation to pre-authorization. You will be financially responsible for all charges.

APPOINTMENTS

1. We prefer accommodating a maximum of two family members on any given day.

2. We require a 24-hour notice for cancellations. There will be a $50 charge for all no-show appointments and/or less than 24 hour notice of cancellation on appointments not dealing with head injury or stroke. There will be a $100 charge for all no- show appointments and/or less than 24 hour notice of cancellation for those patients being evaluated due to head injury or stroke.

Thank You,

1. I have read your privacy policy, and office financial policy and agree to it terms.

2. I authorize you to use or disclose my protected health information if my insurance is being billed and/or in the manner described in this notice. I am also acknowledging that I am able to access this notice on www.drsutervision.com website or that I have received a copy of this authorization.

3. I have read and understand that I am responsible for all charges related to the above statements. If my insurance company is to be billed, I authorize the release of any medical, or other, information necessary to process a claim. I also request payment of benefits to Dr. Penelope S. Suter, O.D. or supplier of services.

This authorization will expire seven years after the date on which you last received services from us.

Signed: _____ Print Patient's Name: _____ Relation:_____ Date: _____