Patient Consent Form

Patient:_____ **DOB**:_____

By signing this release, I authorize Eyes of the World Optical to bill my insurance for appropriate coverage and authorize payment to be made to Eyes of the World Optical.

Please be advised, your insurance may not cover all services and/or materials. Authorization does not constitute payment and I understand that I am ultimately responsible for this account, including incurred legal expenses and to redeem fees if necessary.

I also consent to the release of my past medical/optical records if they are deemed necessary for my eyecare needs.

X_____

I consent Eyes of the World Optical to the release of medical records for the purpose of Health Care Operations*. I understand that I may revoke this consent by written request, at anytime, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical record if I request such restriction in writing. I also understand my request may be denied, if such information is required for Health Care Operations.

X_____

*Health Care Operation include, but not limited to, provider review functions, claims processing and payment, and quality assessment. This consent is in response to new Federal Laws that require patient consent for insurance processing.

A Copy of notice can be made available upon request.

Medicare Patients ONLY:

We will attempt to bill Medicare and/or supplemental on your behalf. Medicare will cover your medical eye care after your yearly deductible has been met. Refraction, or any check for glasses prescription is not covered. There will be a fee of $35 for this service.

X_____

Contact Lens Fees and Policies

Contact Lenses are not part of a standard comprehensive eye exam and may require follow up visits. Your contact lens prescription is valid for 1 year. At the end of that year, a new exam and fitting will be required to renew your prescription.

Contact lens exams and fees are not fully covered by Insurance. Your contact lens fitting fee will range from $64-$124 depending on the prescription, the type of lens, and the number of follow up visits required. You will be responsible of these fees at the time of service.

____ 1. I wish to proceed with Contact Lens services at this time, and I understand the contact lens fees and policies, as stated above.

____ 2. I do not wish to proceed with contact lens services at this time. It is not possible to receive a contact lens prescription without a contact lens fitting.

X_____