DR. BLAKE BUSH

FAMILY EYE CARE

Authorization for Release if Identifying Health Information

I authorize the professional office of my optometrist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not the sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. State and federal laws can change this possibility. We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature _____ **Date**_____

Print Name _____

If signing as representative of patient, please state relationship _____

Insurance Authorization

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay in advance the deductible, co-insurance, or any other balances not paid for you by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill. In signing this statement you agree to be financially responsible for all charges.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for care provider in writing. A photocopy of assignment is considered to be as valid as the original.

Signature_____ **Date**_____

Contact Lens Services

All patients wearing contact lenses will undergo a contact lens fit to evaluate comfort, prescription power and corneal health at your annual exam. This revalidates your prescription for one year.

Any new patient to our office, new brand of contact lens, or new contact lens wearer will be examined and counselled as to an optimal type, Rx, and brand of contact lenses for each individual's needs. Below are the categories of fitting fees. Your fees will be determined by the physician. **Fees are due at the time of the fitting and are non-refundable.** Fees do not include the price of the contact lenses.

- **Complex Evaluation** **$75.00**
  - First time contact lens wearer
  - Includes training for insertion, removal, storage and cleaning.
  - Multifocal/Monovision Fit

- **Single Vision/ Update Service** **$45.00**

- **Specialty Contacts** **$150.00 & Up**
  - Rigid Gas Permeable
  - Hybrid Gas Perm/ Soft Contact
  - Medically Necessary

Also included in your fitting fee is **two months** of follow-up care. During this time, you may return to the clinic as needed to adjust the prescription and manage any problems with vision or comfort you may encounter without additional charges for contact lens related services. After this period, additional services related to the contact lens fit may incur a $45 fee.

The price of lenses will vary depending on type and prescription. Some types of contacts are not available in complimentary trials. These lenses must be purchased before the fitting begins. They may be returned or exchanged as described in the next paragraph. Most soft disposable contacts are available in complimentary trials.

Contacts must be paid for in full when you order your supply. In the event you decide contacts are not for you, your **unopened** boxes of soft lenses can be returned for credit if they are **not expired.**

THE FITTING FEE WILL NOT BE REFUNDED OR CREDITED.

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered.

_____ _____

Patient Name Date

_____

Signature of patient or legal guardian