Bowersox Vision Center, PSC

CONSENT FOR TREATMENT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that **(1.)** you intend that this consent is continuing in nature; and **(2.)** you consent to treatment in this office. The consent will remain fully effective until it is revokes in writing, You have the right at any time to discontinue services.

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have been given an opportunity to **read / review / ask questions** to my satisfaction about how the medical information about me may be used and disclosed. By signing below, I acknowledge that I understand my rights fully and have no further questions regarding the HIPAA privacy policies. I acknowledge that I have read and/or been offered a copy of Bowersox's Vision Center's Notice of Privacy Practices as it relates to HIPAA.

ADVANCE BENEFICIARY NOTICE

Medicare and some other carriers do not pay for refraction. There will be a $30 (generally) fee for refraction if your insurance does not cover refraction. Refraction is the part of the exam where your glasses or contact lens power is determined.

☐ Check this box if you would like to **not** have this part of the exam done.

COMMUNICATION

Bowersox Vision Center (BVC) will contact you using the phone number you provided. Unless you indicate otherwise, your spouse may receive medical information from this office about you. You agree to receive communications concerning your visit / treatment / account / notification that materials are ready for pick-up.

☐ Check this box if **you do not want** to be contacted with the phone number provided.

☐ Check this box if **you do not want** your medical information discussed with your spouse.

INSURANCE

Further, I directly assign any insurance benefits to Bowersox Vision Center, PSC. All benefits, if any, otherwise payable to me for services and goods rendered. I understand that I am financially responsible for all charges whether or not they are paid by my insurance carrier. I here by authorize the doctor to release all information necessary to secure payment for benefits. I also understand that any balance over 30 days old is subject to a $10 per month billing fee.

There are two types of coverage that will help pay for your eye services and optical products. You may have both types and BVC accepts most **Medical insurance** (such as Blue Cross/Blue Shield, Medicare and others) as well as **vision discount plans** (such as VSP and others).

- **Vision plans** only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- **Medical insurance** must be used for medical eye care & does not cover the refraction fee.
- If you have both types of insurance plans, it may be necessary for us to bill services to both plans to minimize your out-of-pocket expense.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays, or non-covered services as allowed by the insurance contract.
    - Unpaid balances will be assessed a finance charge if the bill is not paid by 30 days following the insurance benefit.
    - Unpaid balances will be sent to collections after four months of non-payment and will be assessed a $75.00 collections fee.

Please provide your insurance cards to our staff members so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

APPOINTMENT POLICY

Tardy Appointment Policy: We provide a 15-minute window for every appointment. If you are more than fifteen minutes late to your scheduled exam, the appointment will be rescheduled for a later date or time. In this instance, BVC will abide by the timestamp in office to determine tardiness.

Cancellation Policy: The office must be notified at least 24 hours prior to the scheduled appointment time. Failure to do so will incur a $25 fee to your account.

Missed Appointment Policy: Missed appointments will also result in a $50 charge.

Same-Day Appointment Policy: After three (3) consecutive missed, cancelled or rescheduled appointments, the patient will be scheduled for same-day appointments only. Appointments will no longer be scheduled ahead of time. In the event this occurs, the patient can contact the office upon opening to request an appointment for that day. If our schedule permits, we would be happy to see you!

I acknowledge that I am responsible for any amounts not covered by my insurance & have been made aware of the Appointment Policy. I understand the information above and have had the opportunity to ask questions to my satisfaction.

Signature: _____ **Date:** _____