Bowersox Vision Center, PSC

Consent for Treatment

This consent provides BVC with permission to perform reasonable and necessary 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 revoked in writing. You have the right to discontinue services at any time.

Notice of Privacy Practices (HIPAA)

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

Advance Beneficiary Notice

Medicare and most other medical insurances do not assume responsibility for the refraction. There will be a $40 or $50 (Complex) fee if your insurance does not cover this service or if the benefit is unavailable. **The refraction is necessary to determine your prescription.**

- ❏ Check this box if you **DO NOT** wish to have this part of the exam completed.

Communication

Bowersox Vision Center (BVC) will contact you using the information that has been provided. Unless indicated otherwise, supplied phone number(s), email and addresses may receive correspondence on your behalf. In furnishing this information, you have agreed to receive communication concerning your visit/treatment/billing and notification of materials to these outlets.
Failure to provide a working email address may result in a $10 service fee for any non-electronic correspondence.

- ❏ Check this box if you do not want to be contacted using the information provided
- ❏ Check this box if you do not want your information discussed with your spouse/partner

Insurance

I directly assign any insurance benefits to Bowersox Vision Center, PSC. This includes but is not limited to, all benefits, allowances or authorizations if otherwise payable to myself for services and goods rendered. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment for benefits.

Vision Insurance will be assigned for routine vision exams along with materials (eyeglasses and contact lenses). Vision plans do not cover medical eye care, the diagnosis of, management or treatment of ocular health conditions.

Medical Insurance will only be billed when there is a medical diagnosis and when warranted. Unless otherwise noted in your plan benefits, medical policies do not cover the cost of refraction or routine exams.

If both types of insurance policies are available, and in an effort to minimize your out-of-pocket expenses, it may be necessary to bill services to both plans. Responsibility of payment may be transferred to the patient in the event of a co-pay, non-covered services or if deductibles have not been met.

Finance charges will accrue to any balance not paid within 30 days following the insurance benefit. I understand that any balance over 30 days old is subject to a $10 per month billing fee. Unpaid balances will be sent to collections after four months of non-payment. A $75 collection fee will be assigned (in addition to the unpaid balance on the account).

Appointment Policy

Tardy Appointment Policy: Late arrival of 15+ minutes will require rescheduling of appointments for a later time or date. Tardiness will be determined at BVC's discretion and will be based on the office timestamp.

Cancellation/Missed Appointment Policy: The office must be notified at least 24 hours prior to the scheduled appointment time. Failure to do so will incur a $75 fee to your account. Missed appointments will also incur a charge in the same amount.

Same day Appointment Policy- After three (3) consecutive missed, canceled or rescheduled appointments, the patient will only be scheduled for same-day appointments or, will require a $75 deposit to be scheduled. This will become a credit on the account and will be applied to any future balance.

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 been given the opportunity for further clarification to my satisfaction.

Signature:_____Date:_____