CONSENT FOR TREATMENT

I hereby give my permission to Mt Hood Eye Care Sandy or Mt Hood Eye Care Gresham to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

AUTHORIZATION FOR RELEASE OF INFORMATION AND PRIVACY STATEMENT (HIPAA)

Mt Hood Eye Care Sandy or Mt Hood Eye Care Gresham may release information from my medical records to any health care provider involved in my care and treatment. Mt Hood Eye Care Sandy or Mt Hood Eye Care Gresham may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, workers' compensation carrier or my employer who is providing payment due to injury on the job. I have received notice that Mt Hood Eye Care Sandy or Mt Hood Eye Care Gresham bides by HIPAA privacy policy.

PATIENT RESPONSIBILITY

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

PAYMENT POLICY

Payment for services is requested at the time services are rendered. For materials ordered, at least a 50% deposit is required at the time of ordering, with the balance due on delivery. If there is a financial burden, please ask to speak privately with the Office Manager.

Cancellations of Prescription lenses ordered must be done within 24 hours of purchase.

The patient agrees to be responsible for all fees not covered by their vision or medical insurance plan. There is a $25.00 fee for any returned checks.