Consent Form

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that I have certain rights to privacy. By signing this form, you acknowledge that you have reviewed our Notice of Privacy Practices and disclosures of protected health information for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I hereby authorize the practice to disclose my medical information so that the practice may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the Practice (e.g., quality assurance). I also authorize the practice to disclose my medical information to insurers and providers outside of the practice when necessary for purposes of my treatment, payment for that treatment, and for their health care operations.

30 DAY PRESCRIPTION GUARANTEE

There are many factors that can affect your visual acuity. Our doctors honor a guarantee on your prescription within 30 days of your initial examination. Fees are separate for your comprehensive exam for glasses, contact lens evaluation, and contact lens materials. The contact lens evaluation includes the initial contact lens evaluation and progress visits within the initial 30 days. Additional visits after 30 days from the evaluation date will be subject to our usual and customary fee of $60 per visit. The additional visits are not covered by insurance. Eyeglass lenses are custom products and are not eligible for refund.

NOTICE OF FINANCIAL POLICY

Payment for service is due, in full, at the time of service. All outstanding accounts turned over to a collection agency will be assessed with an additional charge of $50.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of the financial policy shall be considered as effective as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits be made directly to Today's Vision.

Authorized Access to Medical Records

I, ____ (patient printed name), chose to grant the following recipients access to my medical records. This includes communication by doctors or staff either verbally in person, via phone, or in writing regarding any conditions, history, prescription and other information contained in my medical chart at Today's Vision Katy. I agree to hold perpetually harmless and free from all liability Today's Vision Katy, its owners, management and staff and their survivors for any subsequent situations arising from such communication that I the undersigned hereby voluntarily authorize.

List anyone you wish to have access to your record (Printed Full Name and Relation)

1. ____
2. ____
3. ____
4. ____

(Print) Patient Name: ____

Patient/Guardian Signature_________________________________ Date:________________