Patient Acknowledgment

Your Provider will make a reasonable, courtesy effort to verify insurance benefits prior to services being rendered; however, insurance verification is not a guarantee of payment. Services will be billed to vision and/or medical insurance based on the care provided. Vision insurance typically covers routine eye examinations and vision-related materials, such as glasses or contact lenses, whereas medical insurance is required when an eye condition or diagnosis is present. The patient understands they are financially responsible for any charges not covered, denied, or reduced by insurance.

The patient accepts responsibility for all balances remaining after insurance processing. For minor patients, the parent or legal guardian accompanying the patient is responsible for all charges incurred at the time of service. In cases of divorce or legal separation, the patient receiving care is responsible for all fees, regardless of court-ordered insurance arrangements.

The patient acknowledges receipt of your Provider's Notice of Privacy Practices and authorizes the use and disclosure of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for purposes of treatment, payment, and healthcare operations. The patient understands that certain services may involve additional fees, including refraction ($45 when not covered by insurance), retinal health screening (starting at $40), and contact lens evaluations (starting at $85), and agrees to be financially responsible for these charges when applicable. The patient also understands that their glasses prescription will be provided at the conclusion of the examination and made available through the patient portal.

The patient agrees to notify your Provider in writing of any changes to contact information or to individuals authorized to receive protected health information regarding the patient's care, account, or treatment plan. Your Provider will rely on the most current information on file unless notified otherwise, in accordance with state and federal privacy regulations.

For minor patients, the parent or legal guardian signing below authorizes the examination and treatment of the minor patient and acknowledges receipt of the Notice of Privacy Practices on the minor's behalf, in accordance with state law.

By signing below, the patient or legal guardian confirms understanding and acceptance of the above policies.

Printed Name of Patient: _____
Patient/Guardian Signature: _____
Date: _____