VISTA EYE SPECIALISTS

POLICIES & AUTHORIZATIONS

REFRACTION POLICY
A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, *DO NOT COVER* routine refractions or routine eye exams. Medicare allows that we charge separately for that portion of the examination, since it is not a covered service. Our office fee for refraction is $ 35.00 and this fee is collected at the time of service in addition to any co-payment your plan may require.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
I understand that Vista Eye Specialists may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a current copy of any current Notice, I understand that I can contact the Privacy Officer at (888) 393-5264.
I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by the agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

PAYMENT INFORMATION
All payments are due at the time of service. If the account has to be turned over to an attorney/collection agency, the undersigned agrees to pay all cost of collections, including attorney fees, interest, and court cost. This form will be placed in your chart and be applicable until such information is changed.

MEDICARE LIFETIME SIGNATURE ON FILE:
I request that payment of authorized Medicare benefits be made on my behalf to Vista Eye Specialists for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:
I, the undersigned, authorize payment of medical benefits to Vista Eye Specialists for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.

REFERRALS
I understand that it is my responsibility to obtain a referral if it is required by my insurance company. I will be responsible for all charges if I am seen without a referral.

By signing below, I acknowledge that I have read and understand these policies and authorizations.

Patient/Responsible Party Signature: ______________________________**Date**:__________