Rocky Mountain Optical and Vision Care

A member of

VISION SOURCE™

Welcome to our office. We appreciate having you as a patient, and look forward to providing health care and customer service that you can be happy with. Please read the following document as it contains important information regarding your privacy, insurance coverage, examination fees, and refund/remake policies. By initialing after each paragraph, you acknowledge that you have read the paragraph and that you agree with and understand the information contained therein.

INSURANCE COVERAGE

The optometrists of Rocky Mountain Optical and Vision Care participate as providers on a number of vision plans, including VSP, EyeMed, Superior Vision, and others; which cover the cost of one comprehensive healthy eye exam per year, and normally includes an allowance for glasses or contact lens materials. We also participate on a variety of medical insurance panels such as Blue Cross, PEHP, DMBA, United Healthcare, and others. Medical insurance often provides coverage for one healthy eye exam per year, and also includes coverage for medical eye care, including infections, injuries, allergies; and management for conditions such as cataracts, glaucoma, macular degeneration, and diabetic eye problems. If the purpose of an exam is to obtain a prescription for glasses and/or contact lenses, the exam will be billed as a healthy eye exam. Otherwise, the exam must be billed to medical insurance as an office visit. If further treatment, testing, or follow-up is required, such visits will also be billed to medical insurance. For that reason, all patients are asked to please provide a copy of their medical insurance cards. There are some insurance companies that selectively exclude optometrists from reimbursement, such as IHC's SelectHealth, as well as some others. If a patient's insurance company refuses to reimburse for services performed in this office, the patient is ultimately responsible for the charges.

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SPECTACLE POLICY

As a service to our patients, we use only the highest quality frames, spectacle lenses, and coatings. Each frame purchased from Vision Source is protected with a 2-year warranty under which a broken or defective frame can be replaced by a $10 fee to the patient **up to two times**. If your purchased frame is no longer manufactured, we will happily arrange a new frame from the same manufacturer if you desire, but we will require new lenses to be purchased with a 50% discount. We cannot take any responsibility in any form for frames not purchased from our office. **Lenses protected with *premium* protective coatings (anti-scratch or anti-reflective) are also warranted for two replacements within two years** against normal wear & tear (scuffing/scratching), as determined by the lab (which excludes negligent damage – caused by pets, for example). **Warranties do not cover loss**, nor do they cover scratched lenses on sunglass lenses or sun clips (unless a separate anti-scratch treatment is paid for and applied). All spectacle lenses are first custom-crafted with each patient's prescription, and then cut specifically to fit the frame the patient has selected. For these reasons, it is not possible to cancel an order or switch a frame after the job has been sent to the lab; and cash refunds are not offered. At the doctor's discretion, patients who are not satisfied with the vision in their new glasses may have their prescription checked and lenses remade **one time** into the original frame at no cost within 90 days of the date on which the order was placed. A second visit to check the prescription within 90 days, or any visit subsequent to the 90 day window will be subject to a $35 office visit fee. Any remake beyond the one-time doctor-redo will be done at a 50% discount to the patient. Patients unable to adjust to new progressive lenses (no-line bifocals) may have their lenses remade into a traditional bifocal or trifocal design, although the progressive upgrade fee is non-refundable. Payment is due for all spectacle orders at the time the order is placed, including lens options not covered by insurance (such as transitions, anti-reflective coatings, tints, etc). For those wishing to purchase a second pair please ask staff for current promotions. All patients will receive a copy of their prescription per the FTC's "Eyeglass Rule" (1992) unless he or she requests *not* to receive a copy. **If you wear contact lenses, please request a copy of the contact lens agreement.**

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PUPIL DILATION

The purpose of pupil dilation is to examine the health of the internal structures of the eye, including the crystalline lens, the optic nerve, the macula, and the retina. In conjunction with other findings from the comprehensive exam, pupil dilation can aid in the diagnosis of cataracts, glaucoma, macular degeneration, and other retinal disease. The doctors of Rocky Mountain Optical and Vision Care recommend pupil dilation for all new patients and periodically thereafter. For patients that have been diagnosed with diabetes or other conditions that may affect the health of the eye, a pupil dilation is recommended at least yearly, or more frequently if indicated.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Vision Health Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ **Yes – I agree to continue my care** as *I have read, had explained, OR was given the opportunity* to me by Vision Health Center, Inc.'s Notice of Privacy Practice with Vision Health Center, Inc. under said terms.

- ☐ **No – I do not wish to continue my care** as *I have read, had explained, OR was given the opportunity* to me by Vision Health Center, Inc.'s Notice of Privacy Practice with Vision Health Center, Inc. under said terms.

APPROVAL OF INFORMATION RELEASE

__ Yes – I grant permission to have my spectacle and/or contact lens prescription(s) emailed to me. I do so with the knowledge that the means by which said prescription(s) will be sent is not encrypted and there is a security risk.
__ No – I do not grant permission to have my spectacle and/or contact lens prescription(s) emailed to me

I authorize the following people to have access to my medical and financial information, unless I specify particulars otherwise. Meaning that the doctors and staff at Rocky Mountain Optical and Vision Care can discuss medical conditions, treatments, insurance coverage, and fees/payments with the following:

(Name)_____(Relation)_____

(Name)_____(Relation)_____

- *I understand that the fees for professional services are due when services are rendered. If I am unable to make payment at this time a 15% service charge will be added to my account. Any exceptions will be made only by specific arrangements before services are rendered.*
- *I understand that I am responsible for payment of this account regardless of insurance company action. I accept that Vision Health Center will attempt to bill my insurance company and/or vision plan for 90 days, after which – if there is no response from or payment made by my insurance or plan –financial responsibility will return to me at which time I must pay in full, then seek reimbursement on my own from my insurance or plan.*
- *I understand that there will be a $20.00 returned check charge, and agree to pay all cost of collections, including 1/3 of any outstanding balance collection fee (up to 40%), plus attorney fee, if necessary, to collect any debt.*
- *I understand that my signature below verifies that I understand the information provided on this document, as well as serves as a "Signature on File", in accordance with HIPAA regulations.*

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

My signature below acknowledges that I have no symptoms of COVID-19 (fever, dry cough, shortness of breath or difficulty breathing, chills or repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell) and that I have made no known contact with infected persons; and is my acceptance of any risk to exposure of COVID-19 that may present during my visit to Vision Health Center, Inc. I accept the steps taken by doctors and staff to limit the number of patients in the office at the same time, disinfect common touch points between every patient, ensure staff and other patients have no symptoms, use of masks and physical barriers, and regularly wash and hands (disinfection required for staff); and recognize that while efforts will be made to maintain a safe social distance of six feet, the testing required in the accomplishment of an eye exam renders that initiative only possible for some of the time in the office. With the possibility of exposure to COVID-19 in many public spaces, I will not hold Vision Health Center responsible should I or my family contract the virus.

Patient Name (Please Print) _____

Signed:_____***Date*** _____

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ _____

Representative Relationship to Patient