TRUSIGHT OPTOMETRY

Welcome to Our Office

Please take a moment to read and fill out this form as completely as possible.

Patient Name: _____

Address: _____ City, State, and ZIP code: _____

HIPAA Privacy - Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice") below, I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and can request a copy for my records on the date identified above. I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use.

Office Billing Policies

I acknowledge, by signing below, that I have provided this Location with all insurance information related to today's services, and that this office will not perform any "back billing" of my services to insurance providers with information provided at a later date. I acknowledge and agree that the Location may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location. Also, if insurance information is NOT provided today, that I will pay the full amount due for services rendered, and bill for the insurance reimbursement myself. Furthermore, if I am not using insurance today, I understand that payment is due today for the services received today. **I understand that no refunds will be issued for services once they have been rendered.**

Authorization for Disclosure of Information to Target Optical

By signing below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize an entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

- Persons/Organizations authorized to use or disclose information: Office of: TruSight Optometry and associated doctors of optometry.
- Persons/Organizations authorized to receive the information: Target Optical.
- Description of information that may be disclosed: Name, address, telephone number, email address, next appointment date and time.
- As part of our **recall program**, the information will be used/disclosed for the following purposes:
  - For the purpose of providing Target Optical service and product information and coupons directly from Target Optical.
  - To compare mailing lists with Target Optical to help avoid duplicate mailings.
- I understand that I may inspect or copy the information used or disclosed.
- I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
  - Action has been taken in reliance on this authorization.
  - If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
- This authorization expires four years from the date of my signature.

Optomap Retinal Exam and Dilated Fundus Exam Policies

Our doctors recommend that all patients have a thorough examination of their retina every year. We are excited to offer state-of-the-art digital retinal scanning technology that allows our doctors to view the inside of your eye **without the use of dilation drops**. Dilation may still be required in rare instances, and patients with a history of epilepsy should **NOT** participate in the Optomap retinal exam.

Patients reserve the right to refuse or reschedule any test or diagnostic procedure recommended. There is absolutely no additional charge for rescheduling your Optomap retinal exam or dilated retinal exam. If a patient refuses, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions. By signing below, I fully understand the circumstances associated if I refuse to have the Optomap retinal screening or have my eyes dilated, and I accept all risk for the possibility of not detecting these conditions and I understand that these conditions may result in permanent blindness, or even death.

PLEASE SELECT AN OPTION

☐ I elect to have the Optomap retinal exam today, and understand that there is an **additional fee of $30.00.**

☐ I decline the Optomap retinal exam, but elect to have my eyes dilated.

☐ I decline both the Optomap retinal exam and dilation at this time.

By signing below, I acknowledge that I have read, understand and agree to abide by all policies listed above.

→ Signature: _____ Date: _____