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 below. 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 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, I understand that all payments are 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.
- This authorization expires four years from the date of my signature.

Retinal Imaging and Dilation Exam Policies

Our doctors recommend that all patients have a thorough examination of their internal eye health. Most vision insurance plans cover a dilated retinal exam in full, but **without insurance there is a fee of $25.00.** Dilation will blur your vision, making reading things up close difficult and causing increased light sensitivity. This will last for 3-5 hours, although it can last longer in some people.

We are excited to also offer the Eidon digital retinal scanning technology at our office. This state-of-the-art, ultra-high resolution retinal imaging allows our doctors to conduct a thorough evaluation of the inside of your eyes **without the use of dilation drops**.

Patients reserve the right to refuse any test or diagnostic procedure recommended, and there is no additional charge for rescheduling any 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 ocular or systemic condition. By signing below, I fully understand the circumstances associated if I refuse to have a digital Eidon or dilated retinal exam, and I accept all risk for the possibility of not detecting these conditions.

PLEASE ☐ I elect to have the Eidon retinal exam today, and understand there is a **fee of $30.00.**

SELECT ONE ☐ I elect to have my eyes dilated if deemed necessary, and understand all associated side effects.

OPTION ☐ I decline both the Eidon 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: _____