Nova Eyecare Center, LLC
450 East Tudor Road, Suite 200, Anchorage, Alaska 99503
ph: 907.274.7825 | fax: 907.274.7826

Acknowledgment & Consent

Health Information | Treatment | Financial Responsibility

Notice of Privacy Practices: I acknowledge receipt of Nova Eyecare's Notice of Privacy Practices.

Treatment: I voluntarily consent to treatment by Nova Eyecare's optometrists for an eye exam and to any related diagnostic procedures to manage my eye health and sight that Nova Eyecare's optometrists determine necessary if I'm at risk for an eye disorder or disease. I acknowledge that the practice of optometry is not an exact science and that there are no guarantees related to such procedures and treatments.

General Health Information: I authorize Nova Eyecare to disclose my medical information internally and to insurers and providers outside of Nova Eyecare for treatment, payment from third parties, and for Nova Eyecare's health care operations. I also authorize Nova Eyecare to disclose my general health information via my email, on my cellphone voicemail, my cellphone text, to my spouse and children, and to anyone else I designate in writing.

Financial Responsibility & Insurance: I am responsible for payment of all Nova Eyecare's services to me regardless of insurance coverage. I am responsible to supply Nova Eyecare with current and correct insurance information. Nova Eyecare will submit both vision and medical claims to maximize benefits, including those related to additional testing. Nova Eyecare does not guaranty payment from your insurance company; does not track coverage and payments; and, does not appeal denials of coverage. I am responsible for any problems I may have with my insurance company. I am aware that my insurance may not cover routine examinations. I understand that insurance companies determine the amounts of and require me to pay my deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered. I hereby assign all insurance proceed payable to me to Nova Eyecare.

I understand that new patients at Nova Eyecare are required to undergo the Optomap Retinal Screening, unless reasonably unable. This screening has a cost of $39. I understand that I have the option of declining this screening during future visits.

I authorize Nova Eyecare to charge my credit card on file or send an invoice for any outstanding balance. If I refuse to make any payment, then Nova Eyecare may decline services to me, file a collection action against me, or assign my account to Cornerstone Collections Services. I shall pay all reasonable attorney's fees and costs in a collection action against me.

By my signature below, I agree to all the above while I am a patient of Nova Eyecare.

Patient Name: _____

Date of Birth.: _____

_____

Patient Signature or Parent Signature for Minor Child (Date)