Name: _____ Date: _____
Last First MI

Address: _____
Street Apt. City State Zip Code

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Email: _____ How did you hear about us: _____

My contact information was verbally verified at check-in, and my insurance card was provided: ☐ _____

Traditional dilation of the eyes
Eye dilation is a routine part of comprehensive eye exams, allowing our doctors to detect diseases that could affect your vision. Your doctor may suggest it today at no extra cost. The drops take about 20 minutes to work, and their effects can last 3 to 5 hours. After dilation, expect temporary blurry vision and increased sensitivity to light, which could impact driving or daily activities. Please plan accordingly for your own comfort and safety.

Patients may refuse any diagnostic procedure or test, despite our recommendations. I understand the risks of refusing these procedures and that without them, the health of my eyes cannot be completely evaluated. Initial here _____

☐ YES I consent to dilation today if recommended by my doctor.
☐ NO I decline dilation today and assume all risks and complications that arise and will not hold Redmond Eye Clinic responsible for any consequences secondary to my decision.

Contact Lens Evaluation Fees
Contact lenses are medical devices regulated by the FDA and require a valid prescription. A contact lens evaluation assesses both the appropriate fit of the lenses and the overall health of your eyes. This professional service is separate from a routine eye examination and has an additional fee which **starts at $90** and increases based on contact lens type.

☐ YES I accept the responsibility for the Contact Lens Evaluation fee.
☐ NO I decline the Contact Lens Evaluation and acknowledge that I will not receive a prescription for contact lenses.

Co-Payments: We are required to collect your Specialist Office Visit insurance co-pay for each visit. The amount of your co-pay is set by your insurance and can vary by visit type.
Cancellation Policy: Any appointment missed, cancelled, or rescheduled within 48 hours will be charged a $75 fee.
Self-Pay: Payment is required at the time of service unless financial arrangements are made in writing.
Collection of deductibles and co-insurance: We collect any anticipated deductible or co-insurance amounts indicated by your insurance plan on the day of your visit. Any difference in amounts will be credited or charged to you accordingly. Credit under $100 remains on your account. Credits over $100 will be refunded.
Account Balances: Payment on any outstanding balance is expected within 90 days of the first statement. The initial statement is sent electronically by email or text through **EyeAppoint.** Additional statements are mailed. If payment is not received in 90 days, a $20 fee will be added, and your account will be forwarded to TSI Profit Recovery for collection.
Secondary Insurance: We are only required to bill the contracted ***primary insurance***. We will provide you with receipts so that you may bill your secondary insurance. Please verify with your secondary insurance what they require for submission.
Glasses Order Cancellation Policy: **Glasses cannot be returned**. The lenses are custom-made for the buyer and cannot be refunded. If you wish to cancel your glasses order that has already been sent to the lab, you will be responsible for 50% of all out-of-pocket expenses. Any claims submitted to insurance will NOT be reversed.
Outside Glasses Troubleshoot Fee: Appointments with our opticians to address problems with glasses purchased outside our office are subject to a $50 fee. This fee is waived if it is determined that the glasses prescription needs to be adjusted by our doctor.
Contact Lens Trial Policy: Contact lens trials are NOT a prescription; we require you to finalize your contact lens prescription within 90 days of your exam.

Vision Plans vs. Medical Insurance

Vision benefit plans such as VSP or EyeMed are not medical insurance. They cover an annual eye wellness exam, a prescription for glasses and/or contact lenses, with a hardware allowance. Vision plans DO NOT cover any medical eye evaluations.

Medical insurance provides coverage for a wide range of health-related issues, including those affecting the eyes. Medical insurance, when available, will be billed for medical condition visits like diabetic eye exams, eye allergies, a scratched cornea, dry eyes, infections, macular degeneration, cataracts, and glaucoma. I understand that non-medical screening tests are not covered by my insurance, and I will be responsible for paying in full for these tests.

Authorization/Financial Responsibility Agreement

Professional services are not refundable, and all product sales are final. Any exchanges that are approved may be subject to a restocking fee.

I authorize payment from my insurance to be paid directly to Redmond Eye Clinic. I understand that billing any out-of-network insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I acknowledge that my portion is to be paid at the time services are rendered, including expected deductible and co-insurance amounts. The undersigned will be responsible for any charges incurred, regardless of insurance. Payment on any outstanding balance is expected within 90 days of the first statement.

For your convenience, our office uses **EyeAppoint**, which allows you to pay online using a credit card or HSA card with a credit card logo. Your initial statement is sent electronically by email or text. **By providing your email address, you agree to receive electronic statements from EyeAppoint.** Additional statements are mailed, and you can use that statement to pay by check if you prefer. There is a $35 service charge on all returned checks.

If payment is not received in 90 days, a $20 fee will be added, and your account will be forwarded to TSI Profit Recovery for collection.

Authorization to Release Medical Information

I authorize the release of medical information regarding myself/my dependent, and my current condition to my referring, consulting, or treating physician. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Acknowledgement of Notice of Privacy Practices

Our full Notice of Privacy Practices describes how your health information may be used or disclosed. I acknowledge that I have reviewed and agree to the terms and conditions of the Notice of Privacy Practices, and upon request, I may obtain a copy at the front desk.

By signing below, I confirm that I have read, agree to, and understand all the information provided above.

_____ _____ _____

(Print Name) (Signature) (Date)

_____

(Relation to patient if minor/not self)

REDMOND EYE CLINIC is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about insurance, our fees, or your financial responsibility.