FINANCIAL POLICY:

As a courtesy to our patients, we file most vision and medical insurance claims. I understand that I am financially responsible for all charges incurred in the event that my insurance denied payment. I also understand any services not covered by Medicare and other insurers that I am responsible for, payment will be collected at the time of service. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED.

Initials ________

Notice of Privacy Practices Patient Acknowledgement

I have had the opportunity to receive this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Initials ________

Please check one:

________ Ok to leave a message regarding any services related to my visit at Jasper Eye Associates

________ Do NOT leave messages regarding any services related to my visit at Jasper Eye Associates

PATIENTS READ AND SIGN AGREEMENT:

1. I hereby give my consent for Jasper Eye Associates to evaluate and treat the patient listed below.

2. I have been provided with the Privacy Practices Notice.

3. I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.

4. I have also been provided with the Financial Policy.

Patient Name (printed): ______________________________________ Date: ____________

Patient or Responsible Party Signature: ______________________________________

I give permission to the following persons to access my personal health records:

____

Contact Lens Evaluation Agreement

Contact Lenses are medical devices that require additinal testing to ensure safety and an accurate prescription. An annual contact lens evaluation is required every year for all contact lens wearers in order to prescribe contacts. The fee for this evaluation is separate from the fee for the routine eye exam. **Some vision plans do cover this fee, while most do not.**

Contact Lens Evaluation Fee

-New patient contact lens evaluation: $60-$120

-Established patient maintenance: $60-$90

The exact fee within these ranges depending on the type of lens and complexity. The exact fee will be discussed with your contact lens technician or doctor. The contact lens evaluation fee includes all of the necessary measurements, training if necessary, and follow ups needed to finalize the prescription of your contact lenses.

By signing this form, you are acknowledging that:

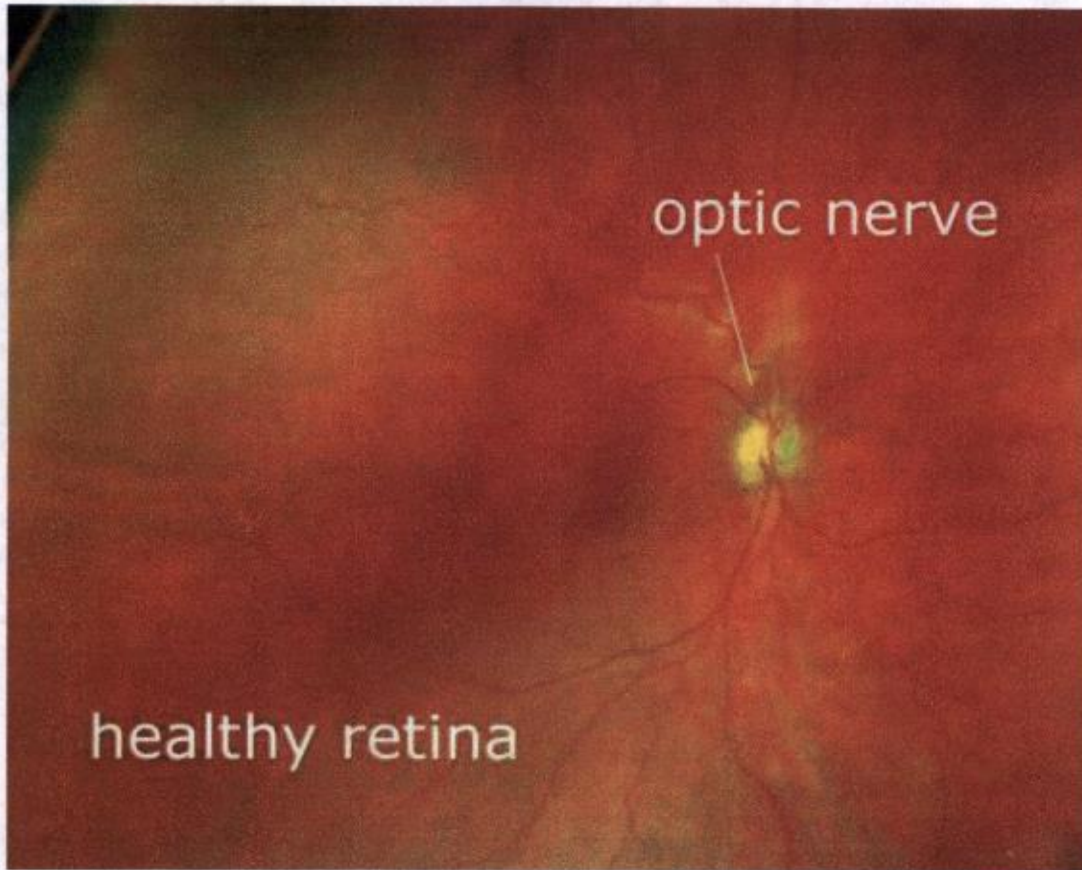
-Contact lens evaluation fees are non-refundable and payment is due at time of service.

-Your prescription is valid for one year.

Patient/Guardian Signature:______________________________

Date: ____________________

OPTOMAP Digital Wellness Retinal Photography



- Why Dr. Darby and Dr. Wright recommend the OPTOMAP:
- The OPTOMAP allows us to see the variations in the eye's structure
- Usually takes the place of eye dilation without any side effects of blurred vision or light sensitivity
- Images can detect undiagnosed diseases in the eye and body such as macular degeneration, glaucoma, diabetes, and cancer
- Early detection can prevent vision loss or other complications

________ YES, I elect to have the OPTOMAP of my retina for $40

________ NO, I would like to have my eyes dilated

Patient Signature ____ Date____________