

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 denies payment. I also understand that payment will be collected at the time of service for copayments, coinsurance, and any other services not covered by Medicare and other insurers. **IF I FAIL TO PROVIDE INSURANCE INFORMATION AT CHECK-IN, I UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE FOR ANY/ALL SERVICES RECEIVED.**

Signature: _____

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 voicemail regarding any services related to my visit at Jasper Eye Associates.

____ Do NOT leave a voicemail regarding any services related to my visit at Jasper Eye Associates.

PATIENTS READ AND SIGN AGREEMENT

1. I hereby give my consent to Jasper Eye Associates to evaluate and treat the listed patient.
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 coordination of healthcare needs of the patient.
4. I have been provided with the Financial Policy.
5. I give Jasper Eye permission to bill services to the insurance company that I provided at the time of service.

Patient Name (printed): _____ Date: _____

Patient (or responsible party) Signature: _____

I give permission to the following person(s) to access my personal health records (if any):

Contact Lens Evaluation Agreement

Contact lenses are medical devices that require additional testing to ensure safety and an accurate prescription. A contact lens prescription is valid for one year from the finalized date. The fee for this evaluation is separate from the fee for routine eye exam and materials. The exact fee within these ranges depends on the type of lens and complexity.

An annual contact lens evaluation is required every year for all contact lens wearers to receive a prescription and/or order contact lenses. The contact lens evaluation fee includes all of the necessary measurements, training if necessary, and 30 days to finalize the prescription of your contact lenses. Any follow ups needed after 30 days will have a \$45 charge.

Contact Lens Evaluation Fee

-New Patient Contact Lens Evaluation: \$60-\$120

-Established Patient Contact Lens Evaluation: \$60-\$90

By signing this form, you are acknowledging that:

-Contact Lens Evaluation Fees are non-refundable and payment is due at the time of service.

Yes, I am interested in a contact lens exam: _____

No, I am not interested in a contact lens exam: _____

Date: _____