NOTICE OF PRIVACY PRACTICES, AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY, &ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I understand that Bauer Eyecare is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. Bauer Eyecare will file insurance coverage for me if I provide them with a copy of my current insurance card. This includes any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing.

I understand that **I am financially responsible for all charges whether or not they are paid by my insurance;** I understand that benefits quoted by my insurance to your staff are NOT a guarantee of payment. I hereby **authorize** the holder of my medical and patient registration records to **release any information needed to process my insurance claims**. I understand that I am the guarantor of this account. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay your balance in full.

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)

2. Medical insurance (such as Aetna and Medicare).

• Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

• Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

• If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. I do acknowledge that there is a $25.00 fee for returned checks. I am aware that if I do not have insurance coverage, I will be responsible for payment. Payment is due at the time of service. All patient balances are due at the time of service unless a formal payment plan is established with the clinic. A $25 per month billing fee will be assessed for any balance over 60 days.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. A $50 fee will be charged for missed or late-cancellation appointments.

"By signing I acknowledge that I have read, understand and agree to this financial policy and authorize assignment of payment directly to Bauer Eyecare for services provided to me. I also authorize the release of pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

INFORMED CONSENT FOR DILATION OF EYES

The purpose of dilating your pupils is to perform a thorough examination of the health of your retina by viewing around the iris. This allows the doctor to access the peripheral retina, an area which would normally be blocked. Individuals with diabetes, glaucoma, high prescriptions, systemic disease, and those over 45 years old or have never been dilated before it is strongly encouraged to have this procedure. However, certain side effects may occur. These include blurry vision, light sensitivity, nausea, dry mouth, and burning upon the installation of drops. These effects can last up to 6 hours. If you should experience the above-mentioned symptoms including decreased vision, halos around lights, foggy vision, brow/ headache, redness, or pain lasting longer than 6 hours call or return to our practice immediately.

OPTOMAP (OPTOS) RETINAL IMAGING

Our doctor strongly recommends having Optomap retinal imaging. The Optomap can provide an ultra-widefield 200-degree retinal image. While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough exam of the retina is critical to verify that the back of the eye is healthy. It can lead to early detection of common diseases, such as glaucoma, diabetes, high blood pressure, macular degeneration, bleeding in the retina, detection of any holes, tears, detachments or even cancer. This test is quick, painless, and does NOT require dilation drops. *(Please advise staff if you have a history of epilepsy.)*

OCT RETINAL SCAN

The OCT retinal exam is a technology that lets the doctor see beneath the surface of your retina in 3D, where signs of disease first appear. Traditional eye exams and retinal photography do not provide this level of detail. This instrument operates using optical coherence tomography to evaluate the optic nerve for diseases such as glaucoma or optic neuritis. It also evaluates for problems and diseases in the macula such as macular degeneration, diabetic retinopathy or macular holes.

If you would like the OCT screening alone for $29

If you would like the Optos screening alone for $39

If you would like the Optos screening and OCT for $49 (recommended)

If you would like to have DRE (Dilated Retinal Exam) $0

If you would like to decline both Optomap, OCT, and DRE (see below) I understand that the potential for partial or total loss of vision may exist due to undetected eye disease. I therefore release Bauer Eyecare and associates from any liability resulting from failure to diagnose or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

COVID 19 PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any conditions that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any symptoms associated with the COVID-19 virus. Like:

- Fever or above normal temperature

- Shortness of breath or had trouble breathing

- Dry cough

- Runny nose

- Recently lost or had a reduction in your sense of smell

- Sore throat

Or if you have been in contact with someone who has tested positive for COVID-19, or if you have been tested positive for COVID-19, or if you traveled outside of the United States by air, bus, train, or cruise ship in the last 14 days.

I fully understand and acknowledge the above information, risk, and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that I don't any of the symptoms, that I haven't been in contact with someone positive to COVID-19, or been my self-tested positive to COVID, or traveled in the last 14 days.

Name: _____ Signature: _____

Date: _____