DOMINION EYE ASSOCIATES
An AVP Company

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT:	DOB:	MRN:

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Dominion Eye, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Dominion Eye.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the Dominion Eye provider of service(s) furnished to me. I authorize Dominion Eye to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Dominion Eye. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Dominion Eye medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a Dominion Eye billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with Dominion Eye's approval, I understand that appropriate collection measures may be initiated. Please be aware, any collection fees are the patient's responsibility.

NO SHOW AND CANCELLATION POLICY: FEE: OFFICE VISIT ($35.00). SURGERY ($75.00) Our goal is to provide you with quality vision care in a timely manner. We have implemented a no show and cancellation policy that enables us to better utilize available appointments for our patients in need of our services. The following policy clarifies our protocol for those patients who fail to keep their scheduled appointment or who cancel without providing 24-hour notice. If you're a Medicaid recipient, you're prohibited from being charged a no-show fee. **If you're a Medicaid recipient you're exempt from the no-show cancellation policy portion of this form**.

Your Responsibility: In order to provide the best care to our patients, we request that you call the clinic promptly if unable to attend a scheduled appointment so that the time slot can be reallocated to someone who may have a more urgent need for treatment. Available appointments are in high demand and your early cancellation will give another person the possibility of more timely access to our care.

Policy: Patients who fail to show for their scheduled appointment and/or did not notify the office within 24 hours of their scheduled appointment time shall be subject to the "No Show/Cancellation" fee amount identified above. In the event of an actual emergency that prevented the proper notice to the office, you may ask for an exemption that will be reviewed to determine if a one-time exception could be granted. While a patient under care in our practice, we will request that you read and sign this form at least once annually to be stored in your chart as documentation that you have been informed of our policy.

ELECTRONIC PRESCRIBING: I understand that Dominion Eye medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my Dominion Eye providers and my pharmacy. I have been informed and understand that Dominion Eye providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Dominion Eye providers to see this health information.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

Witness to Signature

Date of Signing

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PATIENT PRACTICE LETTER OF UNDERSTANDING

Welcome to our practice! We are pleased that you have chosen us to handle your vision care. Below are some guidelines that will help us build a strong and mutually beneficial physician-patient relationship.

PATIENT RESPONSIBILITIES: If you experience discomfort or do not feel well upon your visit, tell us right away so we can help. If you have questions about your care or would like to obtain information about alternative care methods not discussed, please ask. We care about your health and we're interested in your concerns. Also, if you perform self-care, please keep accurate records and provide them to us regularly so we may add notes to your confidential medical record. Lastly, feel free to ask what you can do to stay healthy and feeling your best. We would love to help!

PHYSICIAN/PRACTICE RESPONIBILITIES: Our providers will make every effort to see you at your scheduled time however, things do happen and our office may run behind. If the office is running behind our staff will keep you updated on your visit status. Your vision services provider may prescribe you with treatments related to your care plan to keep you seeing your best and our technicians work under the supervision of the physician to perform diagnostic tests and exams. Please feel free to ask our staff any questions you may have during your visit.

SAFETY AND RESPECT FOR YOUR FELLOW PATIENTS: Our office does not permit smoking, weapons, or illegal drugs in the clinic. Please wear clothes that are clean and appropriate for your visit and we ask that your do not swear, raise your voice, or make angry gestures to other patients or the care team. Please treat others as you would like to be treated and follow all infection control policies currently in place within the facility. Please refrain from touching any machines or equipment without permission.

CHANGE OF INSURANCE: Please let us know right away if your health insurance plan or carrier changes. It is your responsibility to give us updated health insurance information. If you cannot afford what your plan doesn't cover, please notify us and we will try to help the best we can.

By signing this agreement, I agree I have read it and will respect myself, my healthcare team, and my fellow patients. I understand that failure to follow these guidelines could result in dismissal from the practice.

PRINT NAME _____ DOB _____

SIGNATURE _____ DATE _____

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize Harman Eye Center and affiliates or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

SIGNATURE_____ DATE _____

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UNDERSTANDING WHEN MEDICAL INSURANCE VS. VISION INSURANCE IS BILLED

Please be aware although you're seeing an eye doctor today, this doesn't guarantee that your vision insurance will be billed. When patients are seen by an eye doctor, for any diagnosis that is considered a medical condition the practice is REQUIRED to bill patient's medical insurance. This is a guideline which we cannot make any exceptions for. Unfortunately, we are not entirely sure if your visit will qualify under a medical or routine eye exam until you're seen by the doctor and they determine a diagnosis. By having you answer the questions below we can get an idea whether your visit may be billed to your medical insurance plan. Vision plans are for routine exams ONLY. Please fill out the questions below and if you would like additional information please, ask the front desk.

1. **PLEASE CIRCLE ANY ISSUES YOU ARE CURRENTLY HAVING:**

*This will help us determine if your visit is a MEDICAL issue or a ROUTINE eye exam

Itchy Eyes	Difficulty reading small print	Problems with glare	"Crow's feet"
Double Vision	Tired of wearing glasses	Watery Eyes	Red Eyes
Swollen eye lids	Difficulty driving at night	Floaters	Headaches
Eye Pain	Can't see fine lines	"Laugh lines"	Change in vision
Droopy Eyelids	Eye Strain	Glasses don't fit or work as well	

2. **DO YOU CURRENTLY WEAR CONTACT LENSES?** NO YES

Are you having problems wearing them? NO YES Are you interested in wearing contacts? NO YES

3. ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICIATIONS?

PLAQUENIL (HYDROXYCHLOROQUINE) TOPAMAX (TOPIRIMATE) GILENYA (FINGOLIMOD)

4. HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

*The following are considered MEDICAL diagnoses and we may need to perform a medical exam

GLAUCOMA CATARACTS DIABETES FAMILY HISTORY OF GLAUCOMA HIGH BLOOD PRESSURE

5. ARE YOU INTERESTED IN ANY OF THE FOLLOWING? LASIK BOTOX JUVEDERM LATISSE

By signing below, I or my legal representative, certify I have read the previous document in its entirety. I acknowledge I was offered additional resources and explanations. I understand the contents and hereby by agree to all terms and conditions set forth above and acknowledge receipt of a copy if requested.

PRINT NAME_____DOB _____

SIGNATURE_____DATE_____