Modern Eyes at Alafaya

FINANCIAL POLICY: It is the policy of Modern Eyes at Alafaya to file insurance on your behalf. Filing a claim is not a guarantee of payment. Your insurance policy is a contract between you and your insurance company; we are not a party to this contract. Although we verify your benefits, please be aware that some, and perhaps all, of the services provided may be non-covered services under your vision/medical insurance. All personal and health information obtained is kept private and confidential except as required or permitted by law for billing your insurance company for payment of services. Co-pays, deductibles and Co-insurance are required billing fees per the contract with your insurance company.

CONTACT LENSES may be covered at a specific benefit amount. This applies towards the doctor's/provider's fee and the purchase of your lenses. If your contact lens benefits have been exhausted the contact lens fitting exam fees may be billed to you. ALL FOLLOW UP EXAMS MUST BE COMPLETED WITHIN 30 DAYS.
After **30 days** you will be charged a New Contact Lens **FITTING FEE**; After 60 days you will be charged a new Contact Lens **EXAM FEE**.
Patient Initials _____

DILATION
I hereby certify that I have received a copy of Modern Eyes at Alafaya's Informed consent for Dilation of the Eyes, and furthermore confirm that I have read, fully understand and agree with the statements contained therein. I hereby make the following choice:
Patient Initials _____

Please check one:
____ **I agree to dilation today.**
____ **I refuse the dilation and understand that I am releasing the Optometrist from any liability.**
____ **I refuse the dilation today and understand that I am responsible for rescheduling my dilation.**
****If rescheduled within 30 days there will be no additional charges.***

WE WILL ADDRESS YOU BY YOUR FIRST NAME IN THE RECEPTION AREA. PLEASE LIST ANOTHER NAME BELOW IF YOU DO NOT WISH TO BE CALLED BY YOUR FIRST NAME: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIM APPOINTMENTS, TREATMENT/BILLING INFORMATION, INFORM ME OF SPECIALS/FUNDRAISERS AS WELL AS CONVEYING MY HEALTH INFORMATION VIA:** ____CELL PHONE/TEXT MESSAGE ____HOME PHONE ____ EMAIL ____ WORK PHONE
*****EMAIL ADDRESS:** _____

I hereby certify that I have read and completed this form fully and accurately and certify that I am the patient or authorized agent to furnish the information requested. I further certify that I have been given written copies of the current effective Notice of Privacy Practices **(HIPAA)** as well as the **INFORMED CONSENT FOR DILATION** for my records. I understand that even if I have insurance coverage, I am financially responsible for all services and when applicable, non-covered services, deductibles and co-insurance or co-payments according to my policy benefits, as well as any collection fees. I hereby certify that the above statements are true and correct. I hereby authorize Modern Eyes at Alafaya to file the claim(s) on my behalf. I further authorize the release of medical information necessary to process such claim(s). I authorize payment of vision/medical benefits directly to Modern Eyes at Alafaya. MY SIGNATURE WILL ALSO ACT AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

PRINTED name (Patient/Legal Guardian/Insured): _____

SIGNATURE (Patient/Legal Guardian/Insured): _____ **DATE:** _____