Five Rivers Eyecare

-Yandell Eyecare -Greeneville Eyecare -Newport Eyecare

Are You Interested In Getting A New Prescription For Glasses Or Contact Lenses Today?

Glasses: _____YES _____NO

Contact Lenses: _____YES _____NO

Refraction Services And Fees

A refraction is a vision test that is used to determine your best prescription for glasses/contact lenses.

A refraction is only covered by vision insurance and **not covered by medical insurance**. Our office fee for a refraction is $30.00 and is not part of your co-pay. All copays,coinsurance,deductibles and refraction costs are collected at the time of service.

I have read the above information and understand that the refraction is not covered by medical insurance.

_____ _____

Signature Of Patient/Responsible Party Date

Contact Lens Fitting And Evaluation Fees

Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. The FDA closely regulates contact lens prescriptions and requires them to be renewed annually per federal law. The contact lens fee is determined by, but not limited to, factors such as type of contact lens, change in prescription, change in brand, and whether this is a new or established fit. Insurance typically does not cover these fees. However, we will apply any insurance or discounts that may be available. The contact lens fee is required at the time of service. Trial lenses cannot be provided until this fee is paid.

Basic Soft Contact Fit (Spherical): $60.00
Specialty Soft Contact Fit (Toric, Monovision, Multifocal): $80.00
RGP (Hard Contact) Fit: $100.00

I have read the above information and understand that I am responsible for the contact lens fee.

_____ _____

Signature Of Patient/Responsible Party Date

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Registration Insurance/HIPPA

Name:_____ Social Security #:_____

Address:_____

Phone:_____ Email:_____

I, or my dependent have:

_____*(Initial)* No insurance coverage/Self-Pay. I understand that I am financially responsible for all charges. I have read and understand the posted financial policy.
_____*(Initial)* Insurance coverage with:

Primary Policy Holder Name:_____ SSN:_____

Insurance Name:_____
Policy#:_____ Group#:_____

_____ *(Initial)* I assign directly to Five Rivers Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I have read and understand the posted financial policy. I authorize the use of the signature on all insurance submissions.

MEDICARE AUTHORIZATION:
_____ *(Initial)* I, request that payment of authorization Medicare benefits be made on my behalf to Five Rivers Eyecare for services furnished me by Yandell Eyecare Center. I, authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cased, the physician or supplier agrees to accept

the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

CONSENT FOR USE OR DISCLOSURES OF HEALTH INFORMATION

We at Five Rivers Eyecare are *very* concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

-We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

-We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

-We may need to use your health information within our practice for quality control or other operational purpose.

-We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (section 164.520). We reserve the right to change our privacy practices as described in that notice.

Your Right To Limit Uses or Disclosures:

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. I have read your consent policy and agree to its terms. I am also acknowledging that I have read a copy of this notice.

Sign:_____ _____
(Print Name and Sign Responsible Party/Beneficiary) (Date)

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VISION VS. MEDICAL

Five Rivers Eyecare is committed to caring for your complete ocular health. Here at Five Rivers Eyecare our patients receive a Comprehensive Eye Health Examination.

As a courtesy to our patients, we are happy to file with your vision plan and/or medical insurance company.

Routine Vision Examinations will be filed to your vision plan (VSP, Eyemed, Davis, etc) if applicable. A routine vision examination means there is no medical complaint or diagnosis. Routine exams include diagnosis of nearsightedness, farsightedness, presbyopia, and include a prescription for glasses and/or contact lenses.

However, should you have a medical complaint or diagnosis (dry eyes, floaters, cataracts, glaucoma, diabetes, "pink eye", foreign body, etc.); your exam is no longer considered routine. This means Five Rivers Eyecare is required to bill today's examination to your medical insurance. This is why we request a copy of both your medical insurance and vision plan cards. We appreciate your understanding.

Thank you,
Dr. Allen Yandell and staff of Five Rivers Eyecare

CONSENT TO TREAT

By signing this form, I consent treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for Five River Eyecare doctors to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the parent/legal guardian of the minor and have the authority to authorize care and treatment.

I have read and agree with the above information.

_____

(Print Name and Sign Responsible Party/Beneficiary) (Date)