# HIPAA Privacy - Acknowledgement of receipt of privacy notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Visions Plus may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Visions Plus to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims, and communicate with me regarding vision care services provided by Visions Plus (for example, mailings of exam reminders or information about services/products provided by Visions Plus).

I can be assured that Visions Plus does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that Visions Plus may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from Visions Plus.

_____ _____

**Patient Signature or Patient's Legal Representative** **Date**

## DILATION CONSENT & NOTIFICATION FORM

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes that will open the pupil and allow a better view of the inside of your eye. The drops used can take 20-30 MINUTES to take effect, will BLUR your vision (more at near) and leave you SENSITIVE TO SUNLIGHT FOR 2-6 HOURS. Our office recommends that you have someone to assist you with driving after your appointment.

Dilation is recommended if you or your family have a history of diabetes, retinal disease, flashes, floaters. glaucoma, cataracts, macular degeneration, a high degree of nearsightedness. It is possible that without dilation ocular health change may not be observed which can lead to future complications. While we believe dilation is an important part of the eye examination process, we understand that you may wish to omit this procedure.

**Please place a check mark to indicate your preference below:**

_____ YES I agree to have my eyes dilated today. _____ NO, I do not wish to be dilated today and can reschedule

## FINANCIAL POLICY

All exam fees must be paid in full at the time of service (including insurance copayments). If using insurance, please provide our office with your most current insurance information before your visit with the doctor, to assure your coverage is utilized properly. All unpaid returned checks will result in a $20 fee. If not resolved, the check will be turned over to a collection agency.

All prescription spectacles require payment of at least half of the amount at the time of order (contact lenses must be paid in full) and will not be dispensed until the balance is paid in full. Prescription eyeglasses are custom orders and all purchases are **non-refundable** and **non-returnable**. Contact lenses purchased from our office can be returned for credit or exchange IF the boxes are unopened AND unmarked.

Our office provides a prescription guarantee policy. If you are not satisfied with your prescription, you have 90 days from the date of purchase to have the doctor re-check the prescription and re-make the glasses if necessary. We are committed to making sure all of our patients are satisfied with their prescription and their eye wear.

_____ YES I agree to Visions Plus Financial Policy.

## PATIENT EMAIL AND MOBILE NOTIFICATION POLICY

Visions Plus may send notification emails to the email address that I have provided and text messages to my mobile number that I have provided. Visions Plus may use an automatic notification system that will send patient appointment reminders/notifications as well as promotional patient marketing. Visions Plus does not sell any patient information to any party and it is all kept confidential. I understand am not required to authorize these services. By selecting yes below I understand that any messages Visions Plus sends me may be accessed by anyone with access to my emails or text messages. I also understand that my mobile phone service provider may charge me fees for text messages that Visions Plus sends me, and I agree that Visions Plus shall have no liability for the cost of any such text messages. At any time, I may withdraw my consent to receive patient notifications simply click "Unsubscribe" to any Email that we send you, or "STOP" to any marketing text message that we send you. If you do not wish to receive patient notifications from Visions Plus, please select no below.

_____ YES I approve text and email messages _____ NO I do not approve text and email messages

**Print Patient's Name: _____ Patient's/Guardian's Signature: _____**