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 been offered 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.

Please list names of any individuals you allow Visions Plus to share
your exam & financial information (spouse, parent, child etc.) →

____ ________________________

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

VISIONS PLUS OFFICE POLICIES

All exam fees must be paid in full at the time of service (including insurance copayments). If using insurance, it is your responsibility to provide our office with your most current insurance information before your visit with the doctor, to assure your coverage is utilized properly. If we are an in-network provider, we are happy to bill your insurance. It is your responsibility to pay any amount not covered by your insurance. Your insurance policy is a contract between you (and possibly your employer) and your insurance company. If your insurance company does not pay for rendered services or products, it is your responsibility to pay the balance in full and resolve discrepancies with your insurance company. All unpaid returned checks will result in a $20 fee per check. 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 (within 60 days of order date).

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.

Any patient arriving fifteen minutes late for their scheduled appointment may be asked to reschedule his or her appointment. Please contact our office if you are running late or need to reschedule.

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.

Email if not previously provided____

_____ YES I approve text messages _____YES I approve email _____ NO I do not approve text messages _____NO I do not approve email

By signing this, I agree to all Visions Plus Office Policies

Print Patient's Name: ____________________________ Patient's/Guardian’s Signature:_________________________________