NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program or medical insurance program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier or medical insurance carrier denies or does not cover my claim for these services. I assume full responsibility for any bill(s) for services rendered mailed to my home/preferred address or sent by email/text. Failure to do so will result in the bill being sent to collections after a three (3) month period.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAYs

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or Scottsdale Eyeology.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Scottsdale Eyeology.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that I am also required to make 100% payment of materials at the time materials are ordered. If I am supplying my own frame (POF), I understand that many plastic and metal products may weaken over time and I will not hold Scottsdale Eyeology or my insurance carrier responsible for accidental laboratory breakage. If a POF frame is broken or lost during the manufacturing process, Scottsdale Eyeology will not be held liable. Scottsdale Eyeology will not monetarily compensate a patient. Under no circumstances, will Scottsdale Eyeology special order a POF. After receiving and inspecting the condition of the frame, our manufacturing laboratory reserves the right to decline placing lenses into the frame. Having read and understood the Disclaimer Statement, I agree to accept the Scottsdale Eyeology POF conditions. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, **no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.**

Routine eyeglass related follow-up care within sixty (60) days of the initial exam is included. After sixty (60+) days, an office visit fee will be charged for follow-up care (based on complexity of the evaluation). Any visit after six (6+) months will be charged as an initial full exam and evaluation. Prescription remakes will not be honored after sixty (60+) days from the purchase date of your new glasses. No refunds will be provided after thirty (30+) days from the purchase date of your new glasses.

Any prescription from our office that is filled at an outside practice/optical/lab will be subject to a $35 lens verification and Rx check fee.

I acknowledge that I will receive my updated glasses prescription at the conclusion of my visit today and will have access to the Patient Portal to access the prescription as well. I authorize the doctor to release my finalized prescription by email if finalized later.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

AGREEMENT

_____	_____	_____
Date of Signing	Guarantor/Patient Signature	Witness

_____

Print Name