ULTRA VISION FAMILY EYE CARE
ESTABLISHED PATIENT CONSENT FORM

Name: _____DOB: _____
Has your contact information (address, phone number, or email) changed within the past two years?
□ NO □ YES: _____
Has anything changed within your medical and/or ocular history?
□ NO □ YES: _____
Any current medications? □ NO □ YES: _____
Do you have any drug allergies? □ NO □ YES: _____

RETINAL ASSESSMENT

Fundus Examinations allow the doctor to see any signs of diseases that may not be detected during a routine eye exam. This is especially recommended for patients with a history of glaucoma, macular degeneration, cataracts, diabetes, high blood pressure, or other problems that may affect the eye. Please choose one of the following Fundus Exams:

Dilated Fundus (Included in Eye Exam) use drops to enlarge the pupil (central, black spot of the eye) to allow a more thorough view of the retina (back of the eye). Side effects include blurred near and intermediate vision with light sensitivity for approximately 4-6 hours. There is no additional charge.

_____ YES, I would like the dilation performed and am aware of the side effects caused by the dilation.
_____ NO, I understand the importance of the dilated examination, but I decline to have it performed at this time. I release Dr. Tam Ha, O.D., and associates from any liability related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information that could have been detected by this test.

Fundus Photo (Additional $39 fee) utilizes a digital camera to capture an image of the retina (back of the eye). There are no side effects. The test will cost an additional $39.00 and is not covered by insurance.

_____ YES, I have no history of seizures and would like the Fundus Photo performed.
_____ NO, I understand the importance of the fundus photo, but I decline to have it performed at this time. I release Dr. Tam Ha, O.D., and associates from any liability related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information that could have been detected by this test.

Visual Field Screenings (Additional $20 fee) utilize a computerized instrument to provide an assessment of your central and peripheral (side) vision. A visual fields test can help with early detection of eye diseases that can lead to blindness, including glaucoma, brain tumors, and optic nerve head diseases. The test will cost an additional $20.00 and is not covered by insurance.

_____ YES, I would like the visual fields test performed.
_____ NO, I understand the importance of the visual fields test, but I decline to have it performed at this time. I release Dr. Tam Ha, O.D., and associates from any liability related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information that could have been detected by this test.

SIGNATURE AND AGREEMENTS

Initial _____ **ALL FEES ARE NON-REFUNDABLE AND MUST BE RENDERED AT TIME OF SERVICE**
I have read the office's financial policy. A copy of the policy may be provided upon request. I guarantee payment of all charges incurred for the account of the above patient.

Initial _____ **CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**
I have received and read the office's HIPPA policy. A copy of the policy may be provided upon request.

Patient_____ Date _____
Parent or Responsible Party _____

ULTRA VISION FAMILY EYE CARE
PATIENT FINANCIAL RESPONSIBILITY HANDOUT

Insurance: our office participates with many vision insurance companies. Should your insurance coverage be with one of these companies, we will bill your insurance accordingly. You are responsible for any co-payments, coinsurance, deductibles, and non-covered services that have not been covered by your insurance. Payments are expected at the time services are rendered. If you have insurance with which we do not participate, we ask that payment be made at the time services are given and your company will reimburse to you any amount due as a courtesy to our patients, we will submit a claim to your insurance company.

I authorize treatment by Dr. Tam Ha. I also authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits to Dr. Tam Ha. If the correct insurance information is not given or the proper referral is not obtained, the patient will be responsible for the bill. If you are uncertain whether or not Dr. Tam Ha or any of our services are covered by your insurance plan, please call your insurance company prior to seeing the doctor.

Self Pay: If you are a self pay patient, paying out of pocket for your services, you acknowledge that you are fully responsible for all financial services and transactions. Payment is due in full at the time services are rendered.

Insurance Billing Policies

1. **I understand that if the office of Dr. Tam Ha, O.D. is not participating provider with my vision insurance, I am fully responsible for services rendered.** As a patient, I understand that it is my responsibility to be aware of my insurance policies *prior* to my routine exam or medical visit, and to inform the office of my insurance in which to file. All insurance inquires should be determined *prior* to the visit to prevent any delays in quality of service.
2. In the event of default, declines, or rejection of claims by me or my insurance carrier, I further agree that I am responsible for unpaid balance of such chargers. If such balance is not paid within 30 days after billing, and the account is referred to an attorney for collection, I acknowledge I will be responsible for acquired attorney fees of the unpaid balance plus all costs of collection.
3. The staff of Dr. Tam Ha, O.D. will assist as possible in your insurance claims as a courtesy. Your eventual reimbursement or coverage will be determined by your insurance carrier. Any deductibles or co-payments are due at the time of your service or immediately upon notification of this office.
4. Most *additional* testing within the office is NOT covered by the insurance. You are responsible for all additional fees that are not covered by your insurance.

Products Policy

1. I understand that all contact lens orders are NON-REFUNDABLE once order has been placed. I acknowledge that I am fully responsible for all costs of my orders. All orders must be picked up within 60 days. If the order(s) are not picked up within 60 days, and there is no communication with the staff, I acknowledge the right to have my order returned.

ALL FEES ARE NON-REFUNDABLE AND MUST BE RENDERED AT TIME OF SERVICE!

I have read and understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the patient. By signing in the appropriate space on the forms given to you, you are agreeing that you understand and accept all financial responsibilities.

ULTRA VISION FAMILY EYE CARE

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our offices.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent form. As described in our Notice to Privacy Practices, the use to disclosure of your health information for treatment purposes not only includes care and services here, but also disclosures of your health information necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent form, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. By signing, you signify that you have provided us with accurate insurance information and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment of services, or performed health care operations.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS