GWYNEDD VALLEY

EYE CARE

Consents and Agreements

Authorization to access electronic prescriptions

I hereby authorize Gwynedd Valley Eye Care PC (GVEC) to view my external electronic prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BBECS medical record.

Authorization for Photograph and Use in Medical Records

I hereby authorize and consent to the taking of photographs or pictures of me by and its agents or employees, and the use and storage of such photographs for identification purposes and as part of my medical record. I hereby release GVEC, its staff, agents and employees from all liability related to the making, storage and use of such photographs for identification purposes as part of my medical record.

Referral to outside providers

You understand and agree that if your insurance company requires you to have a referral for service provided by out of network providers, you are responsible for obtaining this. The physician(s) and provider(s) at GVEC may refer you to providers that are out of network for you. If you desire to be referred only to in-network providers, then you may contact your insurance company for a list of active in-network providers for the relevant service and we would be happy to help you select from within that list.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize through its physicians, employees and/or agents to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiologic, and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BBECS physician(s), including, but not limited to, collecting and testing of bodily fluid, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I consent to pharmacologic dilation of my eyes by the use of eye drops. I understand that this is a very commonly performed step in ophthalmic examinations, but that there are uncommon but potentially serious side effects. These may include, but are not limited to, angle closure and glaucoma, headache, cardiac arrhythmia (usually temporary if it occurs), and hypopnea. **IF I AM PREGNANT OR THINK I MIGHT BE PREGNANT, I WILL NOTIFY THE STAFF MEMBER OR PHYSICIAN IN PRIVACY BEFORE DILATION DROPS ARE INSTILLED IN MY EYES.** While dilation drops are likely to be generally safe during pregnancy due to the small quantity and route of administration, extra precautions are taken during pregnancy to minimize and/or delay exposure.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the provider(s) in GVEC for the services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments, and benefit services that are out of network, denied and/or not covered by my health insurance plan. I authorize GVEC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross or any other insurance carriers or their authorized agents any information needed for this or a related claim.

FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates. We ask for your help by understanding and cooperating with our Financial Policy.

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company **AND** your doctor's bill for services provided is an agreement between you and your doctor.

YOUR Responsibility: Our physician(s) participate with several insurance companies. It is ***your*** responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment.

All co-payments, co-insurances, deductibles and payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

Referrals: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment of services provided if you fail to supply all required referral forms.

Acuity of need

ALL INSURANCE PLANS, including but not limited to Medicare Replacement Plans, Managed Care and Commercial Carrier Plans: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent you will be responsible for paying the fee for all services at the time of service.

PAYMENT FOR SERVICES PERFORMED

1. Our office accepts Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards and Personal Checks for payment of service. A small service charge may be applicable to all credit card and debit card transactions, and you will be advised of such charge at the time of payment should you use one of these methods.
2. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.
3. All payments re expected at the time of service. Should your account require action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
4. **A $20 charge may be added to all amount due over 30 days. RETURNED CHECK FEE IS $30**

CHARGES TO ACCOUNT: We shall retain the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up for an appointment, or fail to reschedule or cancel with the less than 24 hours' notice will be charged a $50.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

MISSED TEST FEE: Patients who do not show up on time for a scheduled office based test, or fail to reschedule or cancel with less than 24 hours' notice will be charge a $100.00 fee. This charge will not be reimbursed by your insurance.

MISSED PROCEDURE FEE: Patients who do not show up on time for a scheduled procedure, or fail to reschedule or cancel with less than 48 hours' notice will be charge a $100.00 fee. This charge will not be reimbursed by your insurance.

RELEASE OF RECORDS: If you require or request a copy of your records for personal use, you must submit a request and pay a copying/printing fee of $1.00 per page, up to State maximum then in effect.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPPA authorization.

RIGHT TO AMMEND: You understand and agree that GVEC may amend the terms of this Financial Policy at any time without prior notification to the patient.

Acknowledgement and Agreement

I acknowledge receipt of the GVEC Financial Policy, and agree to all terms and conditions therein.

I acknowledge receipt of the Notice of Privacy Practices (Health Insurance Portability and Accountability)

I agree to allow access to my electronic prescription records as directed above.

I agree to the photograph policy above.

I agree to the referral to outside providers as above.

I agree to the release and assignment of benefits as described above.

I agree to treatment as described above.

I have read this form, my questions have been answered, and I understand and agree to its content.

_____

Patient Name

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, print name of Signatory

Relationship to Patient/Authority to Sign for Patient

Disclosure to designated person

I allow GVEC to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

_____ _____

Print Name Date of Birth

_____ _____

Relationship Phone number

_____ _____

Print Name Date of Birth

_____ _____

Relationship Phone number