Receipt of Notice of Privacy Policies & Consent Form

Daynes Optical/Lincoln J. Daynes, OD
400 W. Fry Blvd. Ste. 9
Sierra Vista, AZ 85635
(520)459-1650

Patient Name_____

In the course of providing service to you, we create, receive, and store health information for treatment purposes. This includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. You are free to refer to *The Notice of Privacy Practices* at any time before signing this form which describes the uses and disclosures in detail. Similarly, the use and disclosure of your health information for purpose of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: (2) our submission of claims to third-party payers or insurers for claim review, determination of benefits and payment: (3) our submission of your health information to auditors hired by third-party payers and insurers: and (4) other aspects of payment described in your *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get a updated copy here at the office.

When you sign this document, 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.

You have the right to ask us to restrict the uses of disclosures made for purposes and treatment payment or health care operations, but as described in our *Notice of Privacy Practices,* we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and health care operations. I acknowledge that I understand the *Notice of Privacy Policies.*

Signature _____ Date_____

If signing as a personal representative of this patient, describe the relationship to the patient and the source of authority to sign this form.

Daynes Optical

400 FRY BLVD STE 9 | SIERRA VISTA AZ, 85635 | (520) 459-1650

Written Financial Policy

Thank you for choosing Daynes Optical Express. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, MasterCard, American Express or Discover

- Care Credit healthcare credit card. Care Credit is the preferred healthcare credit card providing special financing and payment options* for out-of-pocket medical expenses. Ask for details.
* Subject to credit approval

If payment cannot be made at time of visit, prior arrangements must be made through billing/ office management. Daynes Optical Express charges $25 for returned checks.

Please note:

It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. **Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (when no medical eye problem is known or suspected).** Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. **You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.**

Vision Plans: If you have a separate plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above.

In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments after your exam.

If your insurance medical/vision plan has not paid your claim within 45 days or denies claim, you will be billed.

Daynes Optical Express requires a 50% deposit for glasses and balance due at delivery. Full payment is required for contacts lens orders.

A fee of $25.00 is charged for all **"No Show**" patients who miss or cancel without a 24 hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print) Patient DOB