*Please print name*: _____

NEVADA EYE CARE OPTOMETRY
Caring for YOU Like Family

**Payment Policy:** We will make every effort for you to receive the maximum benefit allowed by your insurance plan. However, in the event that your insurance later determines you were ineligible for care at the date of service or you haven't paid your deductible or you were eligible but for a lesser amount of coverage, you agree to be responsible for any charges incurred and not paid for by your insurance plan. You understand and agree that if your account must be referred to any third party for collections, you will be responsible for any and all costs related to the collection action, including but not limited to; collection agency percentage fees, court costs and reasonable attorney fees and a $30 charge or 10% of the outstanding balance (whichever is greater) will be added to my account balance.

All glasses sales are final and no refunds will be made except for store wide credit because once the fabrication process is started, the lab charges us for the glasses (the prescription lenses are custom cut to your frame and cannnot be reused.) Should you have a problem with adaptation to a particular lens style or frame, we can remake your glasses, however, you will not be reimbursed for any lesser price difference since the lab charged us for the original glasses ordered.

Your signature below verifies you understand the Payment Policy.

_____

*Signature* *Date*

***Method of Payment for Applicable Fees Today**: _____ Cash _____ Debit Card _____ Credit Card*

***Refraction Fee for Medical Plans***: The part of the comprehensive eye exam that determines your prescription for glasses is called the refraction. MEDICAL Plans, such as Medicare, Aetna, Cigna, BCBS, etc., **do not cover the refraction fee** so you will be responsible for the payment of ***$50.00*** if you want to have your prescription glasses updated. Your signature below verifies you understand the refraction fee.

_____

*Signature* *Date*

***Privacy Policy***: 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 services, and to conduct healthcare operations involving our office. The *Privacy Policy* describes these uses and disclosures in detail.

*I acknowledge that I have been offered and/or receive a copy of the Privacy Policy from Nevada Eye Care Optometry.*

_____

*Signature* *Date*

NEVADA EYE CARE OPTOMETRY
Caring for YOU Like Family

*Please print name*: _____

***PREVENTIVE CARE PHOTOGRAPHY AND IMAGING:***

***Digital Retinal Photography***: As part of your comprehensive eye exam today, we recommend getting a high resolution *digital photograph* of your retina. Taking a photograph today will serve as a baseline for comparison (a picture is worth a thousand words) at future visits by acting as a disease management tool if problems develop such as macular degeneration, retinal blood vessel occlusion (stroke), glaucoma, diabetic rtinopathy, or trauma for example. We will also give you a copy of the photos for your records in a document protector and send a copy to your doctor of choice to aid in his treatment. Insurance plans do not cover the ***$45.00*** fee, so you would be responsible for the payment if you would like to have the photograph taken.

_____ I wish to have the *digital retinal photograph* taken.

_____ I do not wish to have the *digital retinal photograph* taken.

*Signature* *Date*

***Corneal Topography Imaging:*** *If you or your family have a history of high astigmatism, keratoconus, pellucid marginal degeneration, other corneal diseases or trauma, it is useful to have a baseline corneal topography performed. This procedure images the front surface of your eye to determine if the cornea has normal shape. Insurance plans do not cover the* ***$50.00*** *screening fee and you will* be responsible for the payment if you wish to have this scan performed.

_____ I wish to have the Corneal Topography performed.

_____ I do not wish to have the Corneal Topography performed.

*Signature* *Date*