EyeRis Vision

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Patient Name_____

Thank you for choosing EyeRis Vision as your eye healthcare provider. Please review this document and sign below.

HIPPA & Notice of Privacy Practice

This Notice describes how your medical information may be used, disclosed, and how you can get access to this information. The details of this Notice is available on our website at www.eyerisvision.com. Paper version is also available by request. Please inform our staff and we will be happy to provide you a copy.
My signature below indicates I have been made aware of this.

Telehealth Notice

Telehealth services is a platform in which electronic technologies are used to communicate and provide clinical health care services remotely.
For example, during COVID-19 pandemic, our doctors could provide consultations via secured communication tools to provide assessment and treatment remotely.
Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telehealth consultations, and all existing confidentiality protections under federal and state law still apply.
My signature below indicates I acknowledge and agree to the use of telehealth technologies when needed.

Financial Responsibility

This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

I understand that if I do not have my insurance card, referral, and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents and/or payments. It is also my responsibility to determine if my plan is a contracted provider with EyeRis Vision. I was made aware that I could pay for services out of pocket and EyeRis VIsion could help provide documents for me to file directly with my insurance carrier.

I understand that EyeRis Vision will collect all co-payments, unmet deductible and coinsurance at the time of the visit. Payment responsibilities are determined by the anticipated billing code(s), details of my Insurance policy, agreement between my insurance company and EyeRis Vision. Any under-payments will be billed to me directly. Any over-payments will be automatically credited to my account or could be refunded at my request. Please allow 3-6 months minimum for insurance processing to occur and for payments/remittance to be posted on my account. All professional fees are non-refundable.

Insurance coverage is not a guarantee of payment by my insurance company. Eligibility and benefits quoted could change once the claim is processed. I am financially responsible for all

services rendered on my behalf or on behalf of my dependents. If my insurance company fails to respond, does not pay within 90 days, I had provided incorrect insurance information at the time of service, or if my plan turned out to be out of network, I will be ultimately responsible for the remaining balance owed. I understand that if I did not pay for my outstanding balances, EyeRis Vision will send me to a Collection Agency. An additional 35% processing fee + $35 administrative fee will be added to my statement. My contact information will be used for collection efforts, including automated dialing systems (for which you may opt out at a later date). Any returned checks for insufficient funds will incur a $35 fee. No additional appointments will be made for delinquent accounts until they are brought current.

I understand that if I am unable to make a scheduled appointment I need to contact EyeRis Vision at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. **A $35 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS and $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE**. If you are 15 minutes late from your appointment time, we reserve the right to reschedule your visit.

General Office Policies

Refraction Policy
Refraction is the process to determine the eye's refractive error for spectacle prescription or to obtain one's best visual acuity measurements. It is an essential part of an eye examination and to rule out any ocular pathology. However, it is NOT a covered benefit by Medicare or certain Medical insurances. Therefore, Refraction fees will be collected in addition to the patient's copay at the time of the visit.

Contact Lens Evaluation Policy
Please be advised Contact Lens Evaluations may NOT be covered by your insurance plans and therefore, will be your responsibility (unless otherwise indicated). All Contact Lens Evaluations include three follow up care appointments within 30 days. After 30 days, any follow ups, switching brands or types of contact lenses, will incur a $30 fee. After 90 days, an office visit charge will be needed for any requested changes.

Annual contact lens examinations are required by law if you plan to continue wearing contact lenses, even when there are no changes in the prescription. Since contact lenses are an FDA regulated medical device, improper use has the potential to cause permanent damage to the eye.

By signing below, I agree to follow the directions given by my Doctors. I also understand complications could arise, especially when the lenses are over worn, when they were slept in, or when they were misused. For Existing Wearers, I already know how to Insert & Remove contact lenses, understand how to properly care and maintain my contact lenses. For New Wearer, I will be under the direct supervision of an office technician for the instruction of contact lens Insertion & Removal. Specific instructions are available on our website at www.eyerisvision.com.

Thank you for choosing us for your eye care needs. Please do not hesitate to ask any of our staff members for additional questions.
I have read and agreed to all terms listed above, that I, or my dependents, will receive.

Signature_____**Date**_____