Perfect Pair Optometry

HIPAA:

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________, acknowledge that I have read and understand Perfect Pair Optometry's "Notice of Privacy Practice" displayed at the check in counter.

Patient/Guardian Signature: _________________________ Relationship to patient: ____________ Date: ________

Insurance/Managed Care Financial Acknowledgement:

I authorize payment for my vision benefits directly to Perfect Pair Optometry. I agree that if my employer, insurance carrier or plan sponsor denies payment of all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at time of service does not guarantee payment.

Patient/Guardian Signature: _________________________ Relationship to patient: ____________ Date: ________

My doctor has informed me of the need for:

Dilated Exam: This exam may include a pupil dilation which is a thorough exam of the back of the eye. The doctor recommends that you have it done at least every two years. The dilation causes blurry vision and sensitivity to light for approximately 4 to 6 hours. It typically extends the appointment by an additional 1 hour.

If you do not wish to have a dilated exam, please initial acknowledging that you have refused the dilation and are aware of the risks. Initialing indicates you DO NOT want to have your eyes dilated during the eye exam.

Initials: _______

Glaucoma eye pressure test: It is also recommended that we perform a glaucoma eye pressure test. I understand that if I have glaucoma and the pressure test is not performed, the disease may go undetected with the potential for a partial or total loss of vision. Initialing indicates you DO NOT want to have the glaucoma eye pressure test during the eye exam. Initials: _______

Receipt of Glasses and/or Contact Lens Prescriptions:

I am signing to acknowledge that Perfect Pair Optometry has provided a copy of my glasses and/or contact lens prescriptions to me if a refractive eye examination was done at my visit, or that I consent to have a copy of my prescription emailed to me after the examination.

Patient/Guardian Signature: _________________________ Relationship to patient: ____________ Date: ________