SHENANDOAH LASIK & CATARACT CENTER
An AVP Company

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT: _____ **DOB:** _____

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Shenandoah LASIK and Cataract Center, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Shenandoah LASIK and Cataract Center.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the Shenandoah LASIK and Cataract Center provider of service(s) furnished to me. I authorize Shenandoah LASIK and Cataract Center to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Shenandoah LASIK and Cataract Center. I hereby authorize that the photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Shenandoah LASIK and Cataract Center medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a Shenandoah LASIK and Cataract Center billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with Shenandoah LASIK and Cataract Center's approval, I understand that appropriate collection measures may be initiated. Please be aware, any collection fees are the patient's responsibility.

ELECTRONIC PRESCRIBING: I understand that Shenandoah LASIK and Cataract Center medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my Shenandoah LASIK and Cataract Center providers and my pharmacy. I have been informed and understand that Shenandoah LASIK and Cataract Center providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Shenandoah LASIK and Cataract Center providers to see this health information.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth

_____

_____

Signature of Patient or Parent/Legal Guardian/Authorized Representative Relationship to Patient if applicable

_____

Date of Signing

PATIENT PRACTICE LETTER OF UNDERSTANDING

Welcome to our practice! We are pleased that you have chosen us to handle your vision care. Below are some guidelines that will help us build a strong and mutually beneficial physician-patient relationship.

PATIENT RESPONSIBILITIES: If you experience discomfort or do not feel well upon your visit, tell us right away so we can help. If you have questions about your care or would like to obtain information about alternative care methods not discussed, please ask. We care about your health, and we're interested in your concerns. Also, if you perform self-care, please keep accurate records and provide them to us regularly so we may add notes to your confidential medical record. Lastly, feel free to ask what you can do to stay healthy and feeling your best. We would love to help!

PHYSICIAN/PRACTICE RESPONIBILITIES: Our providers will make every effort to see you at your scheduled time, however, things do happen, and our office may run behind. If the office is running behind our staff will keep you updated on your visit status. Your vision services provider may prescribe treatments related to your care plan to keep you seeing your best and our technicians work under the supervision of the physician to perform diagnostic tests and exams. Please feel free to ask our staff any questions you may have during your visit.

SAFETY AND RESPECT FOR YOUR FELLOW PATIENTS: Our office does not permit smoking, weapons, or illegal drugs in the clinic. We ask that you do not swear, raise your voice, or make angry gestures to other patients or the care team. Please treat others as you want to be treated and follow all infection control policies in the facility. Please refrain from touching any machines or equipment without permission.

CHANGE OF INSURANCE: Please let us know right away if your health insurance plan or carrier changes. It is your responsibility to give us updated health insurance information. If you cannot afford what your plan doesn't cover, please notify us and we will try to help the best we can. By signing this agreement, I agree I have read it and will respect myself, my healthcare team, and my fellow patients. I understand that failure to follow these guidelines could result in dismissal from the practice.

PRINT NAME _____ DOB _____

SIGNATURE _____ DATE _____

RELEASE OF MEDICAL INFORMATION By signing below, I authorize Shenandoah LASIK and Cataract Center and affiliates or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

Name _____ Phone Number _____ Relationship _____ Name _____ Phone Number _____

Relationship _____ Name _____ Phone Number _____ Relationship _____

SIGNATURE_____ DATE _____

UNDERSTANDING WHEN MEDICAL INSURANCE VS. VISION INSURANCE IS BILLED

Please be aware although you're seeing an eye doctor today, this doesn't guarantee that your vision insurance will be billed. When patients are seen by an eye doctor, for any diagnosis considered a medical condition, the practice must bill the patient's medical insurance. This is a guideline which we cannot make any exceptions to.

Unfortunately, we are not entirely sure if your visit will qualify under a medical or routine eye exam until you're seen by the doctor, and they determine a diagnosis. By having you answer the questions below we can get an idea whether your visit may be billed to your medical insurance plan. Vision plans are for routine exams ONLY. Please fill out the questions below and if you would like additional information, please ask the front desk.

1. **PLEASE CIRCLE ANY ISSUES YOU ARE CURRENTLY HAVING**: *This will help us determine if your visit is a MEDICAL issue or a ROUTINE eye exam.

Itchy Eyes	Difficulty reading small print
Problems with glare	Double Vision
Tired of wearing glasses	Watery Eyes
Red Eyes	Swollen eye lids
Difficulty driving at night	Floaters
Headaches	Eye Pain
Change in vision	Droopy Eyelids
Eye Strain	Glasses don't fit or work as well

2. **DO YOU CURRENTLY WEAR CONTACT LENSES**? NO YES

Are you having problems wearing them? NO YES

Are you interested in wearing contacts? NO YES

3. **ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICIATIONS?**

PLAQUENIL (HYDROXYCHLOROQUINE) TOPAMAX (TOPIRIMATE) GILENYA (FINGOLIMOD)

4. **HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?**

*The following are considered MEDICAL diagnoses, and we may need to perform a medical exam

GLAUCOMA CATARACTS DIABETES FAMILY HISTORY OF GLAUCOMA

HIGH BLOOD PRESSURE

5. ARE YOU INTERESTED IN LASIK? NO YES

By signing below, I or my legal representative, certify I have read the previous document in its entirety. I acknowledge I was offered additional resources and explanations. I understand the contents and hereby agree to all terms and conditions set forth above and acknowledge receipt of a copy if requested.

SIGNATURE _____ DOB _____ DATE_____