TEXTING PERMISSION

WITH MY INITIALS, I AM GRANTING PERMISSION FOR SPRINGBORO EYE CARE AND RAR OPTOMETRY INC. TO TEXT ME WITH BOTH MEDICAL AND MARKETING INFORMATION. I UNDERSTAND THAT AT ANY TIME I MAY OPT OUT OF TEXTING OPTIONS.

Patient/Guardian Initials: _____

FINANCIAL RESPONSIBILITY NOTICE

NOTICE: WE WILL FILE YOUR VISIT WITH YOUR PRIMARY INSURANCE CLAIM. FOR YOUR INFORMATION, BECAUSE OF THE VARIATION OF INDIVIDUAL INSURANCE CONTRACTS WITHIN INSURANCE COMPANIES, YOU, THE MEMBER, ARE RESPONSIBLE FOR BEING INFORMED ABOUT YOUR PERSONAL ELIGIBILITY AND BENEFITS ***PRIOR*** TO RECEIVING SERVICES AND/OR MATERIALS. IF YOU REQUEST A SECONDARY INSURANCE TO BE FILED FOR YOU, THERE IS AN ADDITIONAL $25 FEE CHARGED FOR THIS SERVICE. ANY INSURANCE CLAIM MADE IN GOOD FAITH AND LATER DENIED BECOMES YOUR RESPONSIBILITY AND IS DUE WITHIN 30 DAYS OF NOTICE OF DENIAL. ANY BILL THAT REQUIRES COLLECTION SERVICES IS SUBJECT TO A 35% FEE BASED ON THE AMOUNT BEING SENT TO COLLECTION. ANY RETURNED CHECK IS SUBJECT TO A $35 FEE. THE MEMBER IS RESPONSIBLE FOR NON-COVERED SERVICES; INCLUDING THE RETINAL SCREENING PHOTOS OF $49.00, AND AUTHORIZES THE DOCTOR TO RELEASE ANY INFORMATION REQUIRED BY THE INSURANCE COMPANY. INSURANCE BENEFITS ARE ASSIGNED TO THE DOCTOR. BY SIGNING BELOW I AM AGREEING TO THESE TERMS AND GIVE MY CONSENT TO BE TREATED AT THIS LOCATION.

Patient/Guardian Initials: _____

IMPORTANT
HIPAA PRIVACY (Acknowledgement of Receipt of Privacy Notice)

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with my regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location). I can be assured that this Location does not sell my personal health of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claim to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

Patient/Guardian Initials: _____

Patient or Parent/Legal Guardian Signature:_____