Acknowledgement of Privacy Practices (HIPAA) And Financial Responsibility

Notice of Health Information Practices: I have been offered a copy of Moscow Family Eye Care's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Moscow Family Eye Care has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy upon request or by visiting www.moscowfamilyeye.com

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Patient Initials

Notice of Financial Policy: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed. It is my responsibility to pay deductibles, co-pays or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider. If I do not have insurance, payment is due at the time of service. I may obtain a current copy of Moscow Family Eye Care's Financial Policy upon request or by visiting www.moscowfamilyeye.com **Many insurance plans may require you to have: specific doctors, pre-certifications, and/or referrals. You are responsible to know the details for your insurance plan.**

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Patient Initials

No Show/Cancellation Policy: We require a 24 hour notice for any cancellations or reschedules. We reserve the right to charge a $50 fee if not notified in a timely manner. We reserve the right to reschedule your appointment if you are more than 10 minutes late to your appointment.

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Patient Initials

Refraction: As part of your examination today, refraction may be performed. Refraction determines the focusing ability of your eyes. It allows the doctor to more completely examine your eyes, to check and prescribe eyeglasses, and to help in the treatment of many eye muscles and eye conditions. **Many insurances including Medicare do not cover this test. If a refraction is performed, you will be responsible for the cost in addition to any copays or deductibles at the time of service. The fee is $45**

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Patient Initials

Glasses/Contact Lens Prescription: I acknowledge I will receive a copy of my final contact lens/glasses prescription at the end of my visit. All finalized contact lens/glasses prescriptions are also available in the patient portal.

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Patient Initials

Consent for Treatment: I hereby give my consent for the authorized personnel of Moscow and Pullman Family Eye Care to evaluate and, if appropriate; render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization.

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Patient Initials

Consent for Minor: As the named minor's parent or legal guardian, I hereby give my consent for the authorized personnel of Moscow and Pullman Family Eye Care to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient's physician (if applicable) or by my personal authorization.

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Patient Initials

I authorize Moscow Family Eye Care to release my medical and/or billed information to the following individual(s):

_____ _____
Name *Relationship to Patient*

_____ _____
Name *Relationship to Patient*

I have read and understood the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

_____ _____
Patients Name (Please Print) *Date*

_____ _____
Patient or Authorized Signature *Relationship to Patient*