BAUER EYECARE

NOTICE OF PRIVACY PRACTICES, AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY, & ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT & CONTACT LENS AGREEMENT

I understand that Bauer Eyecare is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. Bauer Eyecare will file insurance coverage for me if **I provide them with a copy of my current insurance card**. This includes any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that **I am financially responsible for all charges whether or not they are paid by my insurance;** I understand that benefits quoted by my insurance to your staff are NOT a guarantee of payment. I hereby **authorize** the holder of my medical and patient registration records to **release any information needed to process my insurance claims**. I understand that I am the guarantor of this account. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay your balance in full.

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:
1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Aetna and Medicare).

• **Vision care plans only cover routine vision exams** along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
• **Medical insurance** must be used if you have any **eye health problem or systemic health problem** that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
• If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. I do acknowledge that there is a $25.00 fee for returned checks. I am aware that if I do not have insurance coverage, I will be responsible for payment. Payment is due at the time of service. All patient balances are due at the time of service unless a formal payment plan is established with the clinic. A $25 per month billing fee will be assessed for any balance over 60 days.

PATIENTS UNDER 18 YEARS OF AGE: Cannot come to their appointment alone, if they do, parents are responsible to contact the office to arrange for payment and to be made aware of recommended treatment plans.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. A $50 fee will be charged for missed or late-cancellation appointments.
"By signing I acknowledge that I have read, understand and agree to this financial policy and authorize assignment of payment directly to Bauer Eyecare for services provided to me. I also authorize the release of pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

INFORMED CONSENT FOR DILATION OF EYES

The purpose of dilating your pupils is to perform a thorough examination of the health of your retina by viewing around the iris. This allows the doctor to assess the peripheral retina, an area which would normally be out of view. Individuals with diabetes, glaucoma, high prescriptions, systemic disease, and those who have never been dilated before it is strongly encouraged to have this procedure. However, certain side effects may occur. These include blurry vision, light sensitivity, nausea, headache, faint feeling, dry mouth, and burning upon the instillation of drops. These effects can last up to 6 hours. If you should experience the above-mentioned symptoms including decreased vision, halos around lights, foggy vision, brow/ headache, redness, or pain lasting longer than 6 hours call or return to our practice immediately.

OPTOMAP (OPTOS) RETINAL IMAGING

Our doctor strongly recommends having Optomap retinal imaging. The Optomap can provide an ultra-widefield 200 degree retinal image. While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough exam of the retina is critical to verify that the back of the eye is healthy. It can lead to early detection of common diseases, such as glaucoma, diabetes, high blood pressure, macular degeneration, bleeding in the retina, detection of any holes, tears, detachments or even cancer. This test is quick, painless, and does NOT require dilation drops. *(Please advise staff if you have a history of epilepsy.)*

OCT RETINAL SCAN

The OCT retinal exam is a technology that lets the doctor see your retinal layers in 3D, where signs of disease first appear. Traditional eye exams and retinal photography do not provide this level of detail. This instrument operates using optical coherence tomography to evaluate the optic nerve for diseases such as glaucoma or optic neuritis. It also evaluates for problems and diseases in the macula such as macular degeneration, diabetic retinopathy or macular holes.

If you would like the OCT screening alone - $29
If you would like the Optos screening alone - $39
If you would like the Optos screening and OCT - $49 **(recommended)**
If you would like to have DRE (Dilated Retinal Exam) - $0
If you would like to decline both Optomap, OCT, and DRE (see below)
I understand that the potential for partial or total loss of vision may exist due to undetected eye disease. I therefore release Bauer Eyecare and associates from any liability resulting from failure to diagnose or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

CONTACT LENS AGREEMENT

First time Contact Lens patients require the following: Contact Lens evaluation, fitting and training
Current Contact Lens patients require the following: Contact Lens evaluation and fitting

Contact Lens evaluation & Contact Lens fitting:
Every year, each patient that wears Contact Lenses must be evaluated for any ocular health changes and changes to their vision and Contact Lens prescriptions. There is a **fee each year** dependent on your lens type and the measurement of your prescription. There are 3 levels of evaluation & fittings - Level 1, Level 2 and Level 3.

Contact Lens evaluation/fit fee: (Cash Price or non-covered insurance price)

Level 1: (Single Vision): $85
Level 2: (Multifocal, Monovision or Toric (astigmatism): $105
Level 3: (RGP): $150 (Multifocal / Astigmatism)
* Medicaid covers contact lens fitting for patients under 21 years of age

Contact Lens training:
Only applies to first time Contact Lens wearers and is to be completed to the satisfaction of the doctor. The fees for Contact Lens Training include 2 sessions for the patient to learn how to wear Contact Lenses; if at that time the patient fails to insert contact lenses successfully the contact lens fitting will be terminated and the contact lens fitting fee will not be returned and it will be used to pay for staff time.

Contact Lens follow up:
All Contact Lens follow ups are included within your Contact Lens evaluation/fit fees. The Contact lens follow up is at no extra charge if it is scheduled within a month and only necessary if the doctor recommends it. Your contact lens exam evaluation includes a follow-up appointment within 60 days of your initial visit. **It is your responsibility to keep your follow-up appointment. It is a must that you wear your trial contacts when you come in for your visit.** If your follow-up is more than 60 days after your initial visit the following fees will apply:
> 60 days - 6 months: $50
More than 6 months: The cost of a new examination

EYEWEAR AGREMENT

At Bauer Eyecare, your satisfaction is our goal and we realize that dissatisfaction usually occurs when expectations are not met. We will stand behind all that we do and want to thank you for putting your trust in us!

1. **WARRANTY POLICIES**

- **Lenses** will be warranted against scratches only if a scratch coating or non-glare treatment is purchased. Warranty covers a **ONE-TIME replacement for scratches and defects for 2 years**.

New lenses will be made with same prescription and treatments only.

- **Frames** will be warranted for 2 years against **manufacturer defects only**. ALL parts must be returned for warranty. * **There will be a fee to cover shipping**

2. **REMAKE POLICIES**

Changes in prescription, material or type of multifocal can be **remade 1 time only within 60 days of the original order** at no charge to you.

3. **PATIENT'S OWN FRAME**

If I'm requesting that Bauer Eyecare put new prescription lenses into my own existing frame. In doing this, I understand that Bauer Eyecare will **not be held responsible if my frame should get lost, cracked, chipped or break in the lens making process or shipping**. If this does occur and new lenses are necessary, I understand I may incur additional costs.

4. **PROGRESSIVE LENS ACCEPTANCE AGREEMENT**

These lenses are the closest lenses available to your natural vision, helping you to see at all distances. We want you to be completely satisfied with these lenses and we need your help to do so by following these guidelines:

- You need to wear the progressive lenses for at least 2 weeks
- Return for adjustments when having difficulty using the progressive lenses
- Return with a decision to keep the progressive lenses before the 30-day adaption period expires
- If you are unable to use your progressive lenses successfully, we will be happy to change to an alternate lens option with no additional charges. However, no refund will occur.

5. **LENS SAFETY**: I have had the benefits of impact resistant Polycarbonate and/or Trivex material explained to me.

6. **DELIVERY TIME**: I understand delivery time is subject to many variables and may not be the date specified. We will do our best and notify you if there will be delays.

7. **ORDER AGREEMENT**: I accept this order as written. Because your prescription is unique to you, **all sales are final, no refunds** on lenses or frames, once the order has been placed. All orders will be placed on the same day you authorize payment. All insurance benefits have been presented. Insurance claims cannot be filed after the order has been placed. **Pupillary distance (PD) is not taken at the time of your exam and is not included on the eyeglass prescription** (not require by the State of Colorado), taking it will have an additional charge of **$20**.

8. **2nd PAIR DISCOUNT**: I have had the 2nd pair discount explained to me and the offer is valid for 60 days. Discount will be 40%.

COVID-19 PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put y/o at greater risk for contracting COVID-19. Please disclose to us any conditions that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.
It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any symptoms associated with the COVID-19 virus. Like:
- Fever or above normal temperature
- Shortness of breath or had trouble breathing
- Dry cough
- Runny nose
- Recently lost or had a reduction in your sense of smell
- Sore throat

Or if you have been in contact with someone who has tested positive for COVID-19, or if you have been tested positive for COVID-19, or if you traveled outside of the United States by air, bus, train, or cruise ship in the last 14 days. I fully understand and acknowledge the above information, risk, and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By Booking an appointment with us **you acknowledge that you don't any of the symptoms, that you haven't been in contact with someone positive to COVID-19, or been tested positive to COVID, or traveled in the last 14 days.**