InSight OPTOMETRY

PATIENT INFORMATION			
PATIENT NAME:		SEX:	
ADDRESS:		DATE OF BIRTH:	
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
VISION INSURANCE:	PRIMARY SUBSCRIBER NAME:	SUBSCRIBER SS#	RELATION TO SUBSCRIBER:
PRIMARY PHYSICIAN	CITY LOCATION OF PRIMARY CARE:	PREFERRED NAME TO BE CALLED:	

GUARANTOR (check here ❑ if same person above)		
GUARANTOR NAME:	SEX:	
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	

NOTICE OF PRIVACY POLICIES

Acknowledgement of Privacy Notice

We are required by law to maintain the privacy of and provide individuals this notice of our legal duties and privacy practices with respect to protected health information. This office will only use and disclose necessary personal health information to another party to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims or mail exam reminders.

By signing below, I acknowledge that a copy of the Notice of Privacy Practices is made available to me.

_____ _____

Patient or legal guardian signature Date

OFFICE USE ONLY

Refusal of HIPAA acknowledgement:

❑ Patient or patient's legal guardian refused to sign.

_____ _____

Doctor or employee signature Date

OFFICE POLICIES

INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for optometric and medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider(s) has settled your plan's covered items, a monthly statement will notify you if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
4. Service fees and insurance coverage will try to be discussed prior to examination. However, I understand that all benefits quoted to me are not a guarantee of payment by my insurance and that final determination can only be made when the claim is processed. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance. Any billing towards a secondary insurance will be my responsibility. Comprehensive eye exams are usually completed on the day of the appointment. In some circumstances follow-ups may be necessary for exam completion. Depending on the complexity, additional procedures or follow-ups may be required and if not covered by insurance, the patient will be responsible for any office visit or procedure fees.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

PURCHASES, WARRANTIES, AND RETURNS: No refund can be made on clinical procedures or services, including comprehensive eye examinations, refractions, contact lens fittings, and medical office visits. All sales of prescription and non-prescription eyeglasses and sunglasses are final. An adaptation period may be normal when wearing new spectacle or contact prescriptions lenses. We advise consistent wear to help with adaptation. If you are experiencing any problems, please schedule an appointment within 45 days from date of purchase or an office visit fee will apply. If there are any discrepancies between the written prescription and prescription lenses manufactured or any changes by the doctors of InSight Optometry, the prescription lenses will be changed once at no charge to the patient within 45 days. If purchased outside our office, an office visit fee will apply if problems are due to outside error. Most frames are covered under manufacturer warranty for any manufacturer defects for one year from the date of purchase. Unfortunately, the warranty does not cover any loss, accidental damage, normal wear and tear or breakage that is incurred to the frame. Unopened, unmarked, and undamaged contact lens boxes may be retuned for a full refund or exchanged within 90 days. All sales of specialty lenses, rigid gas permeable lenses, and lenses in vials are final.

DISPENSING GLASSES AND CONTACTS: All prescription glasses and contact lenses that have been purchased by the patient or customer will be stored in the office for one year from the date of transaction or purchase. If these purchases are not picked up within that year, purchases will become the property of InSight Optometry. InSight Optometry will not be responsible for safe keeping and providing the purchases for the patient or customer.

PAYMENT AND FEES: Payment is expected on the day services are rendered or when glasses, contacts, and materials are ordered. Accepted forms of payment are cash or credit. We may accept personal checks from returning patients or customers only. Checks are not accepted from new patients or new customers. Returned checks are subject to a $25.00 fee. We prefer not to use this method but if a collection service is needed, the customer will be responsible for fees incurred from use of the service. Patients who no show for their appointments will be charged a $30 fee, which must be collected before rescheduling.

We reserve the right to change our office policy at any time without prior notice. Any change will be effective immediately and the most updated policies will be available in our office. The information that I have reviewed and provided is correct and to the best of my knowledge. A photocopy or scan of this agreement is to be considered valid as an original.

_____ _____

Signature of patient or legal guardian Date

Name of Patient:

_____

Authorized representative's name

InSight OPTOMETRY

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Phone: (510) 741-9900
Fax: (510) 741-9910

DIGITAL RETINAL CAMERA & OPTICAL COHERENCE TOMOGRAPHY SCREENING

ADDITIONAL PATIENT TEST OPTION……. $39

THIS TEST IS NOT REQUIRED FOR A COMPREHENSIVE EYE EXAM. HOWEVER, IT IS RECOMMENDED BY DR. NG AS IT GIVES ADVANCED INFORMATION FOR FORMING DIAGNOSES EARLIER. THIS CAN MINIMIZE THE EFFECTS TO YOUR VISION ON ANY DISEASES FOUND. THIS DOES NOT REPLACE A DILATED EXAM.

The Digital Retinal Camera is used in supplement to your comprehensive eye exam, **capturing a picture of the inside of your eye.** These photos are used as a baseline to evaluate subtle changes, for monitoring progress of diabetes, glaucoma, macular degeneration, or other retinal diseases. This screening takes approximately 5 minutes and is recommended yearly.

The Optical Coherence Tomography is the **latest technology in cross-sectioning and imaging high-resolution 2D and 3D images** of your retina and optic nerves. This valuable diagnostic tool is used in conjunction with the retinal camera in diagnosing and managing many eye conditions and disease.

As with other new advanced equipment, your insurance plan may not cover the cost of the screening.

☐ **YES,** I want to take advantage of the retinal camera and will pay the $39 fee today.

☐ **NO,** I decline this additional test.

Signature: _____ **Date:** _____