RUBIN EYE CENTER

Patient Informed Care Consent Form for Services Rendered

Today's Date: ____________________

I understand that the following procedures are available in this office: *Routine Vision Exams (includes refraction and dilation unless contraindicated; wellness retinal photos at $39) *Contact Lens Exams *Glaucoma-related Services *Cataract-related Services *Diabetic-related Services *Treatment of Red Eye/Injury *Medical procedures are generally not covered by vision plans such as VSP or EyeMed

Your Initials______

I understand that during a routine vision exam/treatment, it may be necessary to change or add procedures due to conditions found during such exam. Examples of such changes include but are not limited to a cycloplegic refraction, corneal topography, visual field testing, or OCT (ocular coherence tomography). I understand that any modifications in my treatment plan will be explained to me. When appropriate, these tests will be submitted to my medical insurance, but I understand that I will be responsible for any copays, co-insurances, deductibles, or other non-covered charges.

Your Initials______

I understand that analgesics (such as used for intraocular pressure testing) and other diagnostic medications, as well as therapeutic medications such as antibiotics, can cause light headedness and/or allergic reactions such as itching, redness, swelling, pain, and/or anaphylactic shock.

Your Initials______

I hereby authorize any of the staff of this office to proceed with and perform the ophthalmic procedures and treatments as have been explained to me. I authorize the release of any information required for insurance processing. I understand that my insurance carrier(s) will be billed and any fees not paid by said carrier(s) will be transferred to me. I realize that I am responsible for payment of these fees. I also acknowledge that I will be responsible for filing any secondary insurance claims. I acknowledge that any account receivable over 180 days is subject to outside collections at an added charge of 35% of the outstanding balance. I acknowledge that this office adds a $50 service charge on any returned checks. I acknowledge that this office cannot accept insurance coverage/discounts on services or materials after they have been rendered. We reserve the right to decline to fill outside glasses/contact lens prescriptions and to decline to adjust and/or repair any glasses not obtained through our office. I acknowledge that prescriptions for glasses and/or contacts are valid for a period of one year.

Your Initials______

PATIENT NAME & Date of Birth__________________________________

PATIENT SIGNATURE____