ADVANCED EYECARE & OPTICAL
499 E WINCHESTER BLVD, STE 101
COLLIERVILLE, TN 38017

PERSONAL INFORMATION VERIFICATION

It is our policy to verify your demographic, medical history, and insurance information at every visit to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you to ***EVERY VISIT.***

Initial _____

ACKNOWLEDGEMENT OF PRIVACY POLICY & PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Advanced Eyecare & Optical has established a Privacy Policy and guidelines for Privacy Practices within their office. This information details the use and/or disclosure of information contained in my medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the Advanced Eyecare & Optical Privacy Policy & Practices has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

Initial _____

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize Advanced Eyecare Group, PLLC (AECG) to apply for benefits on my behalf for covered services rendered. I also assign my benefits and request that all payments from my insurance company are made directly to AECG.

I certify that the information reported regarding my insurance is correct. I further authorize AECG to release to my insurance company and its agents any information related to this or any related claims.

I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurance company. If our office has not received payments within a 60-day period of filing your claim, you are responsible for paying the full balance.

Initial _____

OFFICE FINANCIAL POLICY FOR FEES, PAYMENTS AND VISION INSURANCE

We invite you to discuss with us any questions regarding our services. The best vision health services are based on a friendly mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit. (i.e. patient balance, co-pay, co-insurance, deductible)

Please remember that insurance is considered a method of reimbursing a patient for fees paid to the doctor and is not a substitute for payment. Some companies paid fixed allowances for certain procedures and others pay a percentage of the charge. **IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.**

I authorize the staff to perform **ANY SERVICES NEEDED** during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

As we reserve time in our schedule especially for you, we feel it is important that you keep your scheduled appointments. Therefore, it is our policy to charge $65.00 per half hour broken appointment fee. This fee is assessed for all appointments, which are not cancelled or rescheduled at least 24 hours in advanced.

I understand the above information and am aware it is **MY RESPONSIBILITY** to inform this office of **ANY** changes to the information I have provided.

Initial _____

PLEASE DO NOT WRITE ON -- WE WILL HAVE YOU INITIAL ON IPAD
PLEASE REVIEW BOTH SIDES

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MEDICAL EYE PROBLEM VISITS

If during your annual eye exam, you have or need treatment for a medical eye problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventative eye exam it may be necessary that a problem /E&M visit be billed along with other testing and/or procedures, which may be subject to MEDICAL INSURANCE COPAYS and/or DEDUCTIBLES.

Initial _____

EYEGLASS POLICY

We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription. Also, all spectacle lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. For all of these reasons, cash/credit card refunds are not possible. At the doctor's discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted one time at no cost, within 30 days of the original purchase date. Cash/credit card refunds are not available on progressive lenses. However, any patient who fails to adapt to their new progressives will have their prescription remade one time into a lens of their choice either single vision or bifocal (round or straight top) at no additional charge.

Initial _____

FRAME RELEASE ACKNOWLEDGEMENT

It is your desire to utilize your existing frame for the fabrication of your new eyewear. Generally this is not a problem; however, occasionally the defective qualities of used frames do not become known until the time of the actual laboratory eyewear fabrication process. At your request, we will be happy to utilize your existing frame' however, you must agree to assume all responsibility. If your frame breaks during eyewear fabrication, you will be responsible for the cost of an alternate frame and if necessary, any new lenses that are required to complete your order for an alternate frame.

Initial _____

CONTACT LENS EXAM POLICY

If you are wanting/needing to get a CONTACT LENS EXAM/UPDATED CONTACT LENS PRESCRIPTION, there IS an additional fee. This exam IS an addition to the Comprehensive Exam and IS done YEARLY. Also, depending on your insurance the CONTACT LENS EXAM, MAY NOT be a covered expense and fees will be due when services are rendered.

Initial _____

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