Thomas P. Reyburn, OD

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Patient Agreement

Patient Name: _____ DOB: _____

Please initial each section after reviewing:

Insurance
When current and complete insurance information is provided then medical and/or vision insurance coverage can be billed as a courtesy. Please include which plan(s) are primary, secondary or tertiary. Most insurance claims will have an amount the patient is responsible for, such as a copay, co-insurance, deductible or overage. A statement will be sent once the insurance coverage gives notification of the patient responsibility amount, if it is not known at time of service. If the insurance coverage is a plan we do not participate with or up to date insurance information is not presented, payment in full is required at time of service. If the insurance plan does not pay the claim(s) within 120 days, the balance will be forwarded to the patient. Please contact the insurance plan with any questions regarding coverage.

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Non-Covered Services
Please be aware that some of the services rendered may not be considered “reasonable or necessary” by Medicare or other insurance companies. Payment for these services must be paid at the time of visit. A few examples are Refraction, Meibomian Gland Expressions and Fundus Imaging/Screening. Fundus Images are taken for documentation purposes. If a medical condition is noted Fundus Image may be billed to your medical insurance or Medicare.

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Contact Lens Fittings
Contact lens fittings are a separate procedure and are not included in a routine vision exam. Contact lens fittings are required for a contact lens prescription. Many insurance companies do not pay for the fitting of contact lens. This fee is due at the time of service. There is no charge for contact lens checks during the first 60 days or first three follow up visits, whichever comes first.

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Compliance to Treatment Plan
It is extremely important for patients to follow treatment plans and comply with all medication directions. This includes attending all required follow-up visits with the doctor to monitor progress and plan of care. Failure to do so can result in permanent injury, recurrence of the condition or cause a complication.

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Material Orders
A 50% deposit is required on all eyewear and contact lens supply orders, even if vision coverage is used. The balance is due when eyewear and/or contact lenses are dispensed. There is a Restocking Fee of 15% of Usual and Customary Charges on all cancelled orders.

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Payment
We accept cash, check and credit/debit cards. Patient is responsible for collection fees, attorney’s fees, court fees etc. on delinquent accounts not paid within 120 days of service.

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Patient Communications
I acknowledge that Ada Vision may send appointment recalls/reminders and eye wear notifications to my email and/or via text to my cellular phone. I understand this will be the only confirmation of appointments and agree to provide 24 hour notice should I need to cancel/reschedule.

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Cancelation, Late and No-Show Policy

- Appointments must be canceled at least 24 hours prior to the appointment arrival time. If a 24 hour notice is not given a cancelation will be charted.
- Arriving 15 minutes after the appointment arrival time will be recorded as a late arrival. It may be necessary to reschedule late arrivals.
- "No shows" will be recorded in patient chart.
- After your second canceled, late, or no-show appointments a $50 fee will be assessed. If three canceled, late or no-show, appointments in a rolling 12 month period are charted an additional $50 fee will be assessed, and dismissal from the practice may be considered.

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Minor Child Consent to Treat
Treatment may include any examination/procedure deemed medically necessary by the treating provider. Treatment may have additional out of pocket costs; payment is expected at time of service. If a minor child presents for an appointment without proper consent, the minor cannot be seen, and a no-show will be noted in the record. This consent does not expire unless revoked in writing.

I give permission for my minor child receive medical treatment from a provider at Ada Vision without a parent or guardian present. I also agree that I am financially responsible for payment of all charges in connection with the care and treatment rendered.

Parent Name _____

Parent Signature _____ Date _____

Patient Acknowledgment, Consent and Authorization
I authorize Ada Vision to bill my insurance for services provided, and to make available any information needed to process my claim. I assign all insurance and/or Medicare benefits to Ada Vision for services provided by them. By signing below your consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The acknowledgment, consent and authorization will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services and treatments. A photocopy of this assignment is to be considered as valid as this original.

Signature _____ Date _____

Acknowledgement of Receipt of Privacy Practices
By signing below, you attest that you have received, reviewed, and understood Ada Vision privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Date _____

Print Name_____

Signature _____

I authorize the following people to have access to or to perform the following tasks:

Name	Relationship	Dispense materials	Medical Records	Schedule Appointments	All
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

☐ Individual refused to sign _____ (staff initials)

Updated 11/5/19