

Dr. Lauren Claborn, OD

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**Consent Form**

PRIMARY INSURANCE INFORMATION

**Medical:**

Name Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Insured Self Spouse Child Other

Policy Holder DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision:**

Name Vision Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Insured Self Spouse Child Other

Policy Holder DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Read**

I assign of all of my medical benefits to the doctors of Denison Optical and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that some fees may not be paid by my insurance and I am will be responsible for all fees that the insurance does not cover. Accounts 90 days-old are subject to collections, and there will be a service charge for any NSF checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time services are rendered.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Policies:**

I acknowledge that I have read and/or received Denison Optical’s Notice of Privacy Practices.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health-Related Communications & Reminders by Mobile Telephone Texting & E-Mail:**

I permit Denison Optical to communicate & remind me about my health-related issues & appointments by texting & e-mail.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preference Mail Phone Call Text Email

**Denison Optical Policies**

**Lab**: Our office is not responsible for any items left over 30 days after the completion of the order. If you choose to use your own frame or lenses, we cannot be responsible for any damage that may occur during the mounting, edging, tinting or dispensing process. If you need an adjustment, and the frame is no longer under warrantee, we cannot be responsible for any breakage or damage that may occur during this process.

**Refund:** We have a no refund, no cancellation policy. All lenses are custom made according to your prescription. We will be glad to work with you on any issues that may occur during the first 60 days. Contact lens cancellations, if and only if approved by lab first, will be subject to a 15% re-stocking fee.

**Payment:** Payment is expected as services are rendered. All glasses and contacts MUST be paid for in full before we can order them. We cannot accept partial payments or checks to hold, unless previous arrangements are made with the Practice Administrator.

**Insurance**: Insurance information must be presented at time of services. No price adjustments will be made after time of service. It is the responsibility of the insured to verify eligibility on all insurance policies prior to their scheduled appointment.

**Warranty/Remake:** Scratch coat and Anti-Reflective warranty is 365 days, unless your insurance has a specific warranty policy. This warranty does not include industrial safety, sports eyewear or mirror coatings. The warranty does not include chips in the lens or breakage. Frame manufacturer defects are covered up to 1 year after purchase with an $8 shipping charge.

**Progressive Non-Adapt Warranty:** The timeframe for non-adapt warranty is 90 days, unless your insurance has a specific non-adapt policy. If you are unable to adapt to the lens, we will provide you new lenses at no charge. No refund on the original purchase will be made. Only 1 non-adapt redo is allowed per patient.

**Notice of Privacy Practices & Denison Optical Policies**

By signing below, I acknowledge that I have reviewed a copy of the “Notice of Privacy Practices” and “Denison Optical Policies”. Signing below signifies that the I agree to the terms and conditions of the agreement stated above.

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Dilation/Refraction Consent Form**

*By initialing below, I acknowledge that I have read and understand the above policies, and I give my informed consent to order the products chosen by my child or myself.*

*If you do not understand any of the information below, please let the front office staff or the pre-testing staff know. They will be happy to answer any and all questions you may have.*

A Dilated Fundus Exam requires the doctor or staff to administer eye drops that will dilate your pupils, enabling her to view the back of your eye in more detail. Dilation allows her to better test for many eye conditions such as; cataracts, glaucoma, and macular degeneration. This is not a required procedure, but if you choose to have your eyes dilated, there is no additional fee. **Side effects** include blurred vision, light sensitivity and increased blood pressure. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. Usually dilation is temporary, but can last several hours. It may affect your ability to operate a vehicle, reading fine print, or operating machinery safely. To reduce the side effects of the dilation, you may be provided with temporary inserts.

I Consent \_\_\_\_\_\_\_\_\_\_ I Decline \_\_\_\_\_\_\_\_\_\_

Your Medicare considers a “Routine Eye Examination” for glasses or contact lenses a “Non-Covered Charge”. Your Medicare will only pay when the examination is for medical reasons, such as cataract, glaucoma, dry eye, macular degeneration, etc. If you have any of these problems, please inform the tech or the doctor so that your chart can be documented accordingly. Also, your Medicare considers “Refraction” a non-covered charge. “Refraction” is required for your glasses or contact lens prescription. If you want a prescription, please inform the technician during pre-testing, and you will be responsible for the $30 - $50 fee plus the 20% the insurance does not cover, unless you have a secondary/supplemental insurance that picks up these charges at the conclusion of your visit today.

I Consent \_\_\_\_\_\_\_\_\_\_ I Decline \_\_\_\_\_\_\_\_\_\_