PINE CREEK VISION CLINIC

ESTABLISHED PATIENT

Legal Name: _____ Date: _____

Nickname: _____Date of Birth: ____/____/____ Sex: _____SSN: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____Primary Phone #: _____Secondary #: _____

Optomap ($39) OR **Dilation** (Please circle one)

Preferred Language: ☐ English or ☐ Other ☐ Decline to Answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Employer or School: _____ Occupation or Grade: _____

Referred by: _____#_____

Release of Information

I authorize the release of information (including the diagnosis, records, examination rendered to me and claims information) to be released to the following*: _____

*The release information will remain in effect until terminated by me in writing.

Insurance Information

Payment Policy: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic. Pine Creek Vision Clinic does not bill Secondary Insurance, if the claim does not cross over it is the patient's responsibility to bill insurance.

Vision Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

Medical Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

Referring Provider: _____

Location: _____

Address: _____

Phone number: _____ Fax number: _____

PCP (Primary Care Physician): _____

Location: _____

Address: _____

Phone number: _____ Fax number: _____

Signed: _____ **Date**: _____

* This authorizes the release of information to be released to the above providers

Payment Policy: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a $50 collection fee."
Signed: _____ **Date**: _____

"I hereby authorize release of information to my insurance company or to any health care professional or educational professional when necessary for my healthcare or billing." (This allows us to bill your insurance.)
Signed: _____ **Date**: _____

Pine Creek Vision Clinic Colorado Springs, CO
ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES
Revised April 1, 2020

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (719) 594-2020.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Dr.
Casey Johnston O.D. and Kassaundra Johnston O.D., F.A.A.O at Pine Creek Vision Clinic, Colorado Springs, CO provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations.
-Pine Creek Vision Clinic, Colorado Springs, CO has a Notice of Privacy Practices and that the participant has the opportunity to review thisnotice.
-Pine Creek Vision Clinic, Colorado Springs, CO reserves the right to change the Notice of Privacy Practices.
-The participant has the right to request restrictions to the uses of their information but Pine Creek Vision Clinic, Colorado Springs, CO will not have to agree to those restrictions.
-The participant may revoke this Consent in writing at any time and full disclosures will then cease.

Pine Creek Vision Clinic, Colorado Springs, CO may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

Signed: _____ **Date**: _____

Office Policies

Thank you for choosing Pine Creek Vision Clinic for your vision care. In order to provide the best care possible for all our patients we request that you take the time to **carefully** review our office policies. Listed below, you will find our policies concerning COVID-19, scheduling, appointments, financial arrangements, and missed appointments.

NOTE: Some of these policies are new, we highly suggest you take the time to read this form in its entirety. Services cannot be provided until this agreement is signed by the patient or patient's legal guardian. By signing this agreement, you acknowledge that you are responsible for all charges/fees that may apply. Thank you for your cooperation

COVID-19 Safety Protocol:

As a healthcare organization we must comply with safety, health standards and regulations. Therefore, safety and care of our staff and patients is an obligation and top priority for the practice.

PCVC will maintain a strict cleaning and disinfecting protocol. We want to assure our patients that the exam lanes, equipment, and office will be continually sanitized and handled with the most caution.

Cancellation and No-Show Policy: Exam slots are limited and valuable. To serve our patients better, we ask for proper notice for any cancellations. All patients are required to provide **at least 24 hours** advance notice when cancelling an appointment so that we may provide other patients with care. We understand that you may miss your appointment due to an emergency, for this reason we also reserve the right to assess each situation on a case-by-case basis. While we do provide reminders the day before the appointment it is the patient's responsibility to remember the appointment.

Patients failing to provide at least a **24-hour notice** ("Same Day Cancellation") or giving no notice at all ("No Show") will be charged a $30.00 or $50.00 fee for a missed appointment. Your fee will be dependent of the type of appointment you had scheduled. After three (3) missed appointments, the practice may at its discretion, choose to discontinue your care.

All fees must be paid before a new appointment can be scheduled.

Late policy: If you arrive more than 10 minutes late to your appointment you will be asked to reschedule your appointment unless the doctor's schedule can accommodate you.

Priority will be given to patients who arrive on time, and you may have to be worked in between them.

Insurance: As a practice we participate in most major insurance plans, including Medicare and Medicaid. It must be understood that if you are insured by a plan we are not in network with or we cannot verify coverage, payment in full will be expected at the time of your appointment. Knowing your insurance is your responsibility. Please contact your insurance company prior to your appointment with us to clarify your coverage/benefits.

Co-payments, Deductibles, and Co-insurance: All co-payments must be paid at the time of service. This arrangement is part of your agreement with your insurance company. Failure on our part to collect co-payments, deductibles, and co-insurance from patients can be considered fraud. Please assist us in upholding the law by paying your insurance costs at each visit.

Self-pay Services: Self-pay patients will receive our self-pay discounts tailored to each service. All charges must be paid in full at time of services rendered. If you have any questions or concerns regarding specific charges or discounts, please ask our staff members prior to receiving services to assure both parties are aware of what will need to be collected on the date of service.

Non-Covered Charges: Please be aware that even if we do take your insurance, we still offer services that are **not covered by any insurance** company. If you decide to receive a non-covered service, it must be paid the same day, in full. We will not bill any of the non- covered services to your insurance company. *These will be the patient's responsibility entirely*. If you have any questions or concerns regarding which services will not be covered by your insurance, please ask a staff member or your doctor prior to receiving care. We will be happy to provide clarification needed.

Referral and Pre-Authorization: It is your responsibility to ensure that any referrals, or pre-authorizations required by your insurance company be provided to our office prior to services being rendered. Failure to obtain required referrals or authorizations will result in you being responsible for the full balance.

Proof of Insurance: All patients must complete our patient information form prior to seeing the doctor. A current and valid insurance card must be presented at time of service. If you fail to provide us with the correct insurance information in a timely manner, **you may be responsible for the balance of the claim.**

Insurance Information: Payment is required when services are rendered, or when materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are **not guaranteed**. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic. Pine Creek Vision Clinic does **not** bill secondary insurance. If the claim does not cross over, it is the patient's responsibility to bill insurance.

Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company. We are not a part of that contract.

Optical Policy: Eyeglasses are custom order prescription medical devices, therefore, are non-refundable.
Patients have 90 days to pick up orders unless an alternative agreement has been made.
Patients have 90 days after the prescription is filled to come in for a complimentary refraction if the prescription is not working. A one-time lens remake within the 90 days, is considered if we determine the prescription needs to be adjusted. It will be the patient's responsibility to replace glasses if they are lost or stolen, regardless of the 90-day period.
If a patient leaves without taking their own lenses or declines to take them after picking up their new glasses, Pine Creek Vision Clinic is not responsible to hold or replace them.
Although we always exercise the greatest of care, we are not responsible for the patient's own frame should it break while we are adjusting, repairing, or reusing the medical device for a new prescription. This includes frames that are purchased elsewhere and brought to us and non-prescription glasses.

Contact Lens Fit: A contact lens evaluation is a necessary and state regulated service in order to ensure the proper fit of a contact lens. **The evaluation is an additional service to the comprehensive eye exam and has a separate fee** that will cover the initial evaluation and all contact lens related follow-up visits for a period of **90 days** from the original appointment. This can range anywhere from $90-$1,000 depending on the complexity and type of evaluation. We do not offer refunds on ordered contact lenses.
*The higher fees for a contact lens fitting are for **specialty** contact lenses. If your provider thinks you may be a candidate for a specialty lens, please inquire at the front desk for additional information on fees that may apply.*

We thank you for your cooperation and for trusting Pine Creek Vision Clinic with your vision needs. We look forward to providing you with the best quality of care!

I, _____ have read the policy and agree to abide by the terms listed above. I understand that if any of the fees listed above may apply, I will be responsible for them in their entirety.

_____ _____

(Patient/parent/guardian signature) (Date)

Effective 2/1/2020