



**Patient Consent for Use and Disclosure
of Protected Health Information**

I hereby give my consent for LOTUS VISION to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by LOTUS VISION describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. LOTUS VISION reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Jess Wilder - Office Manager), 3400-A Old Milton Parkway – Suite 520, Alpharetta, GA 30005.

With this consent, LOTUS VISION may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, LOTUS VISION may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, LOTUS VISION may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that LOTUS VISION restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow LOTUS VISION to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LOTUS VISION may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

**SHOULD YOU MISS A SCHEDULED APPOINTMENT WITHOUT PROVIDING AT LEAST
24 HOURS NOTICE YOU WILL BE CHARGED A \$20.00 CANCELLATION FEE.**



LOTUS VISION POLICIES and PROCEDURES

SHOULD YOU MISS A SCHEDULED APPOINTMENT WITHOUT PROVIDING AT LEAST 24 HOURS NOTICE YOU WILL BE CHARGED A \$20.00 CANCELLATION FEE.

ALL COPAYS AND NON COVERED CHARGES ARE DUE AT TIME OF SERVICE. Any required co-payment will be collected at the time of service and the remaining amount billed for you. If we are not contracted with your insurance company or you have not met your deductible, payment is due upon your visit.

ALL RETURNED CHECKS WILL BE SUBJECT TO BE RE-DEPOSITED ELECTRONICALLY WITHOUT FURTHER NOTICE AND ARE SUBJECT TO A PROCESSING FEE OF \$25.00 OR THE STATE LIMIT FOR ANY UNPAID CHECKS.

BILLING MEDICAL VS VISION INSURANCE

- Though we are willing to verify your insurance coverage for you, we do so as a courtesy. Ultimately, you are responsible for any remaining balance that your insurance denies or deems as a non-covered service. To ensure that you receive the proper coverage, please contact your insurance company.
- **IT IS YOUR RESPONSIBILITY TO UNDERSTAND BOTH YOUR MEDICAL AND VISION INSURANCE.** Although the examination that you receive may be the same or similar to previous visits, the reason for the exam and the doctor's diagnosis dictate how we must bill our patients.
- Medical insurance will be billed for all appointments other than annual routine care. Medical concerns such as cataracts, blurry or dry eyes, and symptoms describing a possible medical problem or any similar medical diagnosis, **MUST BE BILLED TO YOUR MEDICAL INSURANCE.**
- Vision insurance may offer to pay for the majority of the cost of a routine eye exam; you may have a copay. A routine eye exam is when your doctor checks your vision, analyzes your eyeglass / contact lens prescription and evaluates your entire eye health. Vision insurance may also cover some of the cost of materials, such as glasses or contact lenses

REFRACTION SERVICE AND FEE

ALL NEW PATIENTS WILL HAVE A REFRACTION PERFORMED, REGARDLESS OF REASON FOR YOUR VISIT VISION OR MEDICAL

- **THIS IS NOT COVERED BY MEDICARE OR ANY MEDICAID PLANS.** Many other insurance plans consider a refraction to be routine medical care not covered under their medical coverage. We will collect this fee if we know in advance it is not covered. We may also bill insurance company and then send a statement if insurance doesn't cover the refraction.
- OUR OFFICE FEE FOR A REFRACTION IS \$30.00 AND THIS FEE IS COLLECTED AT THE TIME OF SERVICE IN ADDITION TO ANY COPAYMENT YOUR PLAN MAY REQUIRE. SHOULD YOUR PLAN PAY US FOR THE REFRACTION, WE WILL REIMBURSE YOU ACCORDINGLY.
- Refraction is how we determine the best possible visual acuity and function of your eye which is essential in medical information for the physician to assess your eyes and look for any problems you may not know of. The refraction is also a way to determine your eyeglass prescription, and typically involves questioning along the lines of, "Is 1 better than 2?"

Please Note: All accounts delinquent past 60 days from date of service will incur a \$35.00 service charge.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or a contact lens evaluation, in addition to any other eye exam services. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee, contact lens evaluation fee, or other non covered procedures.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

Effective January 2012



INFORMATION REGARDING DILATING EYE DROPS

The dilated fundus exam is a crucial part of an eye examination because it can detect signs and physiological effects of various circulatory, metabolic, glaucoma and neurologic disorders such as high blood pressure, diabetes and some tumors. It can also aid in the diagnosis and assessment of many eye disorders. Dr. Nemi will administer special eye drops to dilate your pupils. This increases the size of your pupil, giving the doctor a larger window in which to inspect the internal eye and determine overall eye health. A thorough retinal examination not only provides clues about your retinal health but also about your overall health and signals evidence of many systemic diseases before their symptoms show up elsewhere in your body.

It is **NECESSARY** to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses. Patients should wear sunglasses, be cautious walking and going up or down stairs. It is not possible for your ophthalmologist to predict how much your vision will be affected.

Most people will be able to drive after this procedure. You will be unable to read “fine” print (i.e. cell phones, books, magazines, and computers). The dilation will affect an adult’s eye for approximately 3-4 hours, for *LASIK* evaluations dilation remains 10-12 hours. For children eyes pupils can remain dilated for 10-12 hours.

LOTUS VISION is committed to patient communication. *Please do not hesitate to ask questions.* We are all here to provide excellence in eye care!

Precautions Following Dilation

The test itself involves minimum to no risk. The dilating eye drops may **rarely** cause an attack of narrow-angle glaucoma (sudden increased pressure in the eye). This is **extremely rare** and treatable with immediate medical attention. The presence of this risk will be assessed prior to administering the drops. If the physician suspects such a risk, the drops will not be administered.

I HEREBY AUTHORIZE DR. NEMI AND/OR SUCH ASSISTANTS AS MAY BE DESIGNATED BY HIM TO ADMINISTER DILATING EYE DROPS ON THIS AND SUBSEQUENT VISITS AS NECESSARY. THE EYE DROPS ARE NECESSARY TO DIAGNOSE MY CONDITION.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

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Explanation of Contact Lens Fees

All patients must sign all policies and procedure forms regardless of reason for visit

Contact Type	New Wearer	Previous Wearer
Standard, Soft, Disposable Lenses	\$50.00	\$35.00
Toric or Multifocal Lenses	\$65.00	\$45.00
Rigid Gas Permeable (RGP) Lenses	\$75.00	\$55.00

The *Contact Lens Fitting* fee includes:

- Contact Lens Exam
- Instructions on Insertion and Removal for New Wearers
- Trial Lenses as Needed
- Lens Care Kit
- Follow-up visits as needed for up to sixty (60) days

A *Contact Lens Fitting* is not part of the standard eye examination and may require a number of follow-up visits. This communication is important to ensure the proper fit of the lenses and health of the eyes. The cost of the *Contact Lens Fitting* is determined by the type of lenses that are required, your prescription, and whether you are a new or previous wearer. If you have never worn contacts before, your fee will fall under the New Wearer column above. If you have worn contacts before, your fee will fall under the Previous Wearer column above.

A minimum 50% deposit is required prior to ordering, with the balance due at the time the lenses are dispensed. If a follow-up is needed for dispensing and the appointment is not kept, we will only hold your lenses for 30 days. After 30 days, the lenses will be returned to the manufacturer and you will be refunded your deposit less a \$15.00 shipping and handling fee. The first or initial pair of contact lens are verified and inspected for defects prior to the initial dispensing. Any damage incurred after dispensing is the responsibility of the patient. Future contact lens orders must be paid in full prior to ordering. If you would like purchased contacts to be delivered to you there is an additional fee of \$6.99 per for shipping and handling.

By state law, contact lens prescriptions are valid for 1 year. Replacement lenses will be dispensed only to those patients whose prescriptions remain valid and have not surpassed the expiration date. A written copy of the contact lens prescription may be released to the patient in accordance with Federal requirements and patient compliance guidelines. Lenses purchased from other sources or suppliers will not be warranted for defects. It is the patient's responsibility to ensure that all lenses purchased from another supplier meet the exact specifications as prescribed by our office.

***These charges cover specific services and will be in addition to other eye examination service charges, including co-pays that you may incur during your visit today.**

Please Note: All accounts delinquent past 60 days from date of service will incur a \$35.00 service charge.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

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