Insurance

All professional services and materials not covered by insurance will be charged to the patient. Payment from my insurance is to be paid directly to **City Eyeworks**. I understand that my primary insurance will be billed on my behalf. 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. **The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance.** Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Initials:_____

HIPAA

I acknowledge that the Notice of Privacy Practices of City Eyeworks has been offered for my review.

Initials:_____

Receipt of Prescriptions

I would like my eyeglasses and/or contact lens prescription sent to me electronically via email.

Initials:_____

Voicemail

I authorize City Eyeworks to leave detailed voicemails regarding treatment and payment at the number on file.

Initials:_____

Email Correspondence

I authorize City Eyeworks to send emails regarding appointments, billing information, and prescriptions. I understand that I may revoke this authorization, in writing, at any time. ***Initials:***_____

Authorization to Release Healthcare Information

I authorize the disclosure of appointment information, prescriptions, and other health information to the following individuals. I understand that I may revoke this authorization, in writing, at any time. ***Initials:***_____

Name: **Relation:** **Information to disclose:**

Name: **Relation:** **Information to disclose:**

Digital Ocular Health Imaging

Baseline retinal imaging is recommended to document the health of your eyes. These images allow the doctor to see the layers of the retina and offer the most detailed evaluation of your internal eye health. Most insurance plans will not cover this service without a medical diagnosis. If there is a medical diagnosis, medical insurance may be billed for this procedure.

_____ **Yes, I would like digital retinal imaging $39** _____**No, I would not like the images taken at this time**

(Optical coherence tomography/Retinal photography)

Printed Name **Signature** **Date**

Contact Lens Policy

Contact lenses are medical devices that require a prescription **separate** from glasses for purchase. Additional assessment is required by the FDA and Washington State law to ensure that the patient's eye health supports the use of contact lenses. The evaluation of contact lenses is **NOT** included in the comprehensive exam.

When are fittings required?

1. At least every 24 months.
2. If you wish to change to a different contact lens brand/material.
3. By Washington State Law, the evaluation **must** be done within 6 months of a comprehensive eye exam.

The Contact Lens Fitting Process

If you've worn contacts before:

The doctor will evaluate the fit and visual acuity of your current prescription. If you are testing a new prescription or a different type of lens, we will dispense trials for you to test. If you are given multiple sets of trials, you must wear or bring the lenses that fit you best to your follow-up. Once we have determined your new prescription and lens type, we will issue a finalized prescription.

If you are new to contacts:

During your exam, the doctor will determine which lenses may be appropriate for you. One of our technicians will instruct you on all aspects of contact lens wear, including insertion and removal. If you can successfully insert and remove lenses **on your own**, you will be sent home with trials. You will return for a follow-up, wearing your preferred trial lenses. The doctor will evaluate the fit and visual acuity. If necessary we will order additional trials. Otherwise, you will receive a finalized prescription.

Yearly contact lens evaluation (no follow-ups needed) $55

Contact Lens Re-Fitting (refitting into a different brand/material or category of lenses): Includes 2 follow-up visits within 90 days of the initial fitting. Further follow-ups will be $35/visit.	
Spherical lens re-fit	**$85**
Toric/Multifocal/Rigid gas permeable re-fit	**$110**

Contact Lens Fitting for New Wearers	
Includes insertion/removal training, lens care instruction, initial fitting and trial lenses, 1 bottle of Blink Contacts Eye Drops, as well as any follow-ups needed within 90 days (follow-ups outside the 90-day window will be $35/visit)	
New spherical lens fitting	**$150**
New Toric/Multifocal/Spherical gas permeable	**$185**
New Toric Multifocal/Bi-toric or Multifocal rigid gas permeable	**$205**

_____Yes, I would like to begin/renew my prescription for contact lenses and consent to receive the contact lens evaluation today.

_____No, I do not want a contact lens evaluation. I understand that I will **not** receive an updated prescription, nor will my eye health be evaluated specifically for the use of contact lenses.

_____ _____

Patient or Guardian Signature Date