Eyewellniss LLC

Name: _____

Phone Number: _____

Email: _____

HIPAA/Acknowledgement of Receipt

This is to notify you that any information you provide us and any information created in the course of providing services to you will only be disclosed or used for the purposes of treatment and care to conduct healthcare operations in our office. I acknowledge that I have been offered and/or give a copy of the Office's Notice of Privacy Practices.

If we do not accept your insurance or if you are ineligible at this time, you are responsible for full payment for services provided at this office. **Our office requires payment/co-pays at the time of service**. Professional services fees are not refundable.

Patient (Parent/Guardian) Signature:_____ Date:_____

Signature on File/Release of Info/Assignment of Benefits

I authorize the release of the provided information to my insurance carrier(s) in order to determine the benefits payable for services rendered. I authorize the doctors in the office to act on my behalf in obtaining payment from my insurance company and that these benefits be made payable to them. *I understand that I am responsible for any copays and/or deductibles that have not yet been met and charges not covered by my insurance.*

Patient (Parent/Guardian) Signature:_____ Date:_____

Optomap - Retinal Imaging

Our office performs the **Optomap** on all patients. This is an alternative to dilation with no side effects to check the overall health of the retina. The optomap will be billed as part of your comprehensive examination with a $45 copay. Please provide your medical insurance and/or vision plan in order to determine coverage for this test.

---

iWellness

We also offer the iWellness to supplement the optomap in checking retinal health. The iWellness is a retinal thickness map and ganglion cell complex assessment giving the doctor detailed information simply not available with other methods. This captures high definition cross sectional images of your retina. There is a $39 charge for the iWellness that is typically not covered by insurance unless being used to actively follow disease.

- ☐ I accept the iWellness.
- ☐ I decline the iWellness.

Patient (Parent/Guardian) Signature:_____ Date:_____

By signing below I agree to the terms in the **Contact Lens Policy** which describes the following:

An annual contact lens evaluation is **medically necessary** for ALL contact lens wearers. Along with updating your prescription, the doctor will check the health of the eyes, curvature of the cornea, inspect the eye for microscopic complications, abnormal blood vessel growth related to wearing contacts and evaluate the fit of the contacts on the eyes every visit. Remember contact lenses are medical device**s.**

First-time contact lens wearers are required to go through training with an additional fee of $100.

- ☐ I have elected to have a contact lens evaluation.
- ☐ I have declined to have a contact lens evaluation.

Patient (Parent/Guardian) Signature:_____ Date:_____