In Focus Eyecare, LLC

Office Policies and Informed Consent

If you are unable to keep your appointment, our office will appreciate a 24-hour cancellation notice. Due to the cost of the professional and physical resources set aside for each appointment slot and the lost care opportunities for those patients waiting to get in, **broken appointments/no-shows will have a $25 charge added to their account.**

Our staff must verify your benefits **before** your scheduled appointment. If benefits have not been verified, you will be responsible for paying all fees today. **In Focus Eyecare will not file claims for services or materials when insurance information is obtained AFTER services have been performed or materials ordered.** Insurances will typically allow you to file for reimbursement for covered services and materials. As a **courtesy** to our patients we will submit claims for you to your insurance carrier for services if we are contracted with the company and we have verified your eligibility before the services have been performed. Information obtained about your benefits by you or us is not a guarantee of payment from your insurance company. **You are responsible for any amount not paid by the insurance company for any reason.** If payment is denied, **it is up to you**, the subscriber, to resolve the issue. By providing us your insurance information and signing this document you are agreeing to have In Focus Eyecare submit your claim and receive payment for the services rendered.

Your copays, deductibles, co-insurances and charges for services are due at the time of your visit. Services are non-refundable. As a courtesy we will submit claims to your insurance company for covered services if we are in network and you have provided the necessary information to us in a timely manner before your appointment. If we receive any payment from them covering what you paid, a refund will be issued to you. Please note that services such as Contact Lens Evaluations are individual and personal procedures and will not be refunded. Not all services are the answer to every patient's needs. There is no guarantee that every patient will be a successful contact lens wearer.

In order to purchase contact lenses, you must have an exam and contact fitting every year in accordance with **South Carolina State Law** (Section 37-25-40). These charges range between $80 and $100 for disposable, more for gas permeable in addition to the fee for the routine eye exam. First time wearers will be charged an additional $20 for training on the proper insertion, removal and care of their contact lenses. The majority of insurance companies **DO NOT** cover these charges. **This is payable at the time service is rendered. A prescription for contact lenses is not given until all money owed for contact services is paid and the doctor has finalized the prescription.**

Changes made to glasses or contacts prescriptions more than one month after the initial exam will require another refraction ($40) and possibly a refit for contacts. Most insurance companies will not cover this. Dr. Neff closes most comprehensive exams after 30 days. If changes need to be made to your prescription, please call the office a few days after your appointment with feedback so your prescription can be tweaked. Please keep in mind that trials may need to be ordered or Dr. Neff may need to see you again before the 30 days are up so do not wait to call.

Any account balances over **30 days** old will be sent to **collections** if payment arrangements aren't made. There will be a charge of **$25 for all returned checks** and the account will be sent to collections within 10 days. Ordered and **abandoned glasses and contacts** (not picked up within 60 days of notification that they are ready) will be **donated** and all payments will be **forfeited** if arrangements due to hardships or travel are not made.

DILATION - Dilating drops are used to dilate or enlarge the pupils of the eye to allow Dr. Neff to get a better view of the inside of your eye. It is best to have your eyes dilated in order to detect tears, holes or detachments of your retina. Dilation also provides Dr. Neff with an opportunity to detect certain diseases that would otherwise be missed. In some cases such as with young children, dilation may be required to determine a proper prescription. **Dilation must be performed to obtain a comprehensive eye examination.**

Everyone should have their eyes dilated. Children should be dilated at their first exam. If you have a history of head trauma, eye surgery, retinal disease, glaucoma, flashes and floaters or unexplained vision loss, then you should be

dilated. If you have been treated for diabetes, high blood pressure, lupus, cancer or any other medical condition, then you should be dilated.

Dilating drops frequently blur near vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for the doctor to predict how much your vision will be affected. Because driving may be difficult for some immediately after dilation due to light sensitivity, you might want to make arrangements not to drive yourself. 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.

Dilation is included in the comprehensive vision exam fee. Most insurance companies require dilation, but under certain circumstances, the doctor may defer dilation to a later time.

Please choose one:

____ I hereby authorize Dr. Neff and/or such assistants as may be designated by her to administer dilating eye drops if required. The eye drops are necessary to diagnose my condition.

____ I refuse dilation. I understand that without dilation or retinal fundus photography, serious eye diseases, such as diabetes, retinal detachment, or malignant tumors (which can result in blindness, loss of an eye, or death) could be present and not detected by the doctor. I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the recommendations of In Focus Eyecare, LLC and their employees, officers, and agents. I am aware that pupillary dilation carries a very small risk of complication including angle closure glaucoma, and will accept medically necessary treatment if complications arise.

____ I would like to reschedule my dilation at this time. (If more than one week later, an office visit charge will apply)

PROTECTED HEALTH INFORMATION (PHI) I hereby give my consent for In Focus Eyecare, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. I authorize In Focus Eyecare to submit claims for the services performed to my insurance company on my behalf and receive payment. In addition, …

Please choose one:

____ I DO NOT give permission for my PHI to be discussed with any individual other than myself.

____ In Focus Eyecare, LLC is authorized to discuss my protected health information (PHI) with the following individual(s):

Name	**Relationship**	**Appointments***	**Financial***	**Medical Info***
_____	_____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
_____	_____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

*****Not limited to the following examples: **Appointments**: Make, confirm, cancel, reason for visit. **Financial:** Billing, balances, invoices, cost of eyewear, placing or canceling orders, insurance. **Medical Info**: Prescriptions, exam/test results, copies of records.

_____
Print Name of Patient

_____ _____
Patient (or person authorized to sign for patient) Date