CLAIR S. MCCASKILL, OD
KERI C. HARTSELL, OD

Patient Name _____DOB _____ SSN_____

Retinal Digital Imaging Consent/Refusal – In order to evaluate the health of your eyes, we will be taking a digital image of your retina instead of doing a dilated examination. If you choose to opt out of this test, we will use dilating drops to evaluate your ocular health.

I agree to pay $35 for this imaging test. Yes_____ No _____ I would like to discuss further_____

Vision vs Medical Exams – During the performance of a comprehensive eye examination, certain medical eye conditions may be revealed that deserve special attention. I understand that there are specific coverage limitations with my vision care plan and that Cairo Eye Care's contract with the vision care plan does not cover medical eye care services. In this event, my medical plan will be billed, and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles. I also understand that Cairo Eye Care will not neglect medical findings to bill my vision plan, as that would put Cairo Eye Care in direct conflict with its ethical obligations to the Georgia Board of Optometry.

(Pt Initial)_____

Privacy Policy Statement – In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office.

I acknowledge that I have been offered and/or received a copy of the Cairo Eye Care Notice of Privacy Practices, which provides a more complete description of information uses and disclosures of my medical records.

(Pt Initial)_____

Financial Disclaimer - Billing of insurance is a service we provide for your benefit. We will make every effort, on your behalf, to collect payment from your insurance company. **Verification of eligibility is done as a courtesy and is not a guarantee of payment.**

Accurate name, date of birth, and social security number are required to file your insurance. Any insurance to be filed must be presented at time of service.

I understand that account balances and copayments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to pay CEC directly. If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full for the remaining balance. My initial is verification that I understand this agreement.

(Pt Initial) _____

Refraction Fee - The part of your evaluation that determines your prescription for glasses and/or contact lenses is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits, your refraction is typically included with your exam benefits. Medical insurances, such as Medicare, typically do not cover a refraction. If you plan to update your glasses, a refraction is necessary.

I agree to pay $29 for a refraction to update my glasses prescription. (Pt Initial) _____

CONTINUED ON BACK →

Contact Lens Patients Only – Updating your contact lens prescription and evaluating how the contact lenses are interacting with your eyes is a separate part of a comprehensive eye exam and requires additional testing that is not a covered benefit with insurance. The fee is typically $39 but may vary if there are any changes made to your lenses during the examination.

(Pt Initial) _____

Glasses and Contact Lens Prescriptions –I would like my eyeglasses and/or contact lens prescription sent to me electronically via patient portal.

(Pt Initial)_____

Materials Agreement - Any glasses that have not been picked up within 6 months and any contact lenses that have not been picked up within 60 days from the date ordered will be returned and no refund will be given. Any ophthalmic lenses are considered special order and cannot be returned or refunded.

Due to the age and wear of an existing frame, they may crack or break when new lenses are inserted or adjusted. We cannot be responsible for any damages or loss to the frame as they are being reused at your request. Regardless of condition or age of the frame, this disclosure applies to any existing frames being reused/adjusted at your request.

(Pt Initial) _____

Emergency contact –

Name _____ Relationship to Patient _____Phone #_____

Financial responsibility –

Name _____ Relationship to patient_____

SSN _____ Birthday_____

Signature _____

Patients name _____

*** If the patient is a minor (*under the age of 18*), this person will be listed as their guarantor.**

During the course of your care in our office, you may wish to have a family member, or a friend, assist you in setting up procedures or obtaining medical information. An authorization is necessary for our staff to release any information regarding your care. Please list below any person(s) to whom you authorize the release of information regarding your care with Cairo Eye Care, LLC.

Name _____ Relationship to Patient _____Phone #_____

Name _____ Relationship to Patient _____Phone #_____