# PATIENT AUTHORIZATION FORM

Patient Name: Today's Date:

This office is committed to providing the highest quality of eye and vision care to every patient. We believe that the most effective way to ensure the complete health of your eyes is to perform a comprehensive examination *each* year. These exams, along with the following highly recommended tests, not only reveal the current condition of your eyes, but also allow for the early detection and diagnosis of many common eye diseases. Please consider these additional tests as they provide important information about the condition of your ocular health.

## OPTOMAP RETINAL EXAM

(This procedure is **NOT** covered by Routine Vision Insurance.)

This optional wellness screening test is an automated procedure utilizing laser-guided technology to scan the inside surface of your eyes producing a high-definition, digital image of your retinas. Once completed, these images are essential in confirming the presence of healthy retinal tissues and/or identifying a broad range of eye diseases. Dr. Wilmes will review your results with you during your exam. In most cases, this procedure CAN BE USED AS A SUBSTITUTE FOR DILATION OF THE EYES. For more information, refer to the information sheet that can be provided by the front desk.

Please choose one of the following options:

- ❑ I wish to have the *OptoMap Retinal Exam* performed on both eyes for an **ADDITIONAL FEE OF $32.00**.
- ❑ I have DIABETES and understand that the *OptoMap Retinal Exam* will be performed as recommended part of my annual diabetic eye examination (with appropriate charges submitted to my medical insurance).
- ❑ I am aware of the significance of the *OptoMap Retinal Exam*, but would prefer to have my eyes DILATED instead*.
- ❑ I fully understand the importance of both the *OptoMap Retinal Exam* and Dilated, but choose to decline both on today's visit.

*Dilation involves placing a few drops of medicine onto the surface of each eye, causing your pupils to widen. A bright light and a special lens is then used to examine the entire inside of your eyes looking for abnormalities, such as cataracts, macular degeneration, glaucoma, diabetes, hypertension, high cholesterol, and many other retinal conditions. *Side effects of this procedure include extreme light sensitivity and blurry vision within arm's length for approximately 4 to 6 hours.*

## VISUAL FIELD SCREENING

(This procedure is **NOT** covered by Routine Vision insurance.)

This optional screening is an automated test used to identify unknown blind spots within your central visual field. It is an informative tool that can assist in detecting early eye diseases such as glaucoma, macular degeneration, eye/brain tumors, strokes, retinal detachments, and many others. Recommended for patients 13 years and older, it DOES NOT REQUIRE DILATION OF THE EYES, nor does it affect your vision in any way.

Please choose one of the following options:

- ❑ ***YES*** – I wish to have a visual field screening on both eyes for an **ADDITIONAL FEE OF $10.00**.
- ❑ ***NO*** – I fully understand the importance of visual field testing, but choose NOT to be tested at this time.

❑ ***YES*** **– I WOULD LIKE BOTH *OPTIONAL* PROCEDURES PERFORMED AT A REDUCED RATE OF $36.00**

*--- Over Please ---*

## HIPAA (Health Insurance Portability and Accountability Act of 1996)

This office is also committed to protecting your personal information at any cost and adheres to all Federal Privacy Guidelines. Please understand that the personal information we collect from you today will ***only*** be used in the process of your medical treatment, communication with your insurance company, and/or during the collection of payment for your care. The HIPAA policies are posted in the office and you may request to have your own copy. Please sign below once you have read and understand the included "NOTICE OF PRIVACY PRACTICES", indicating that you are aware that this office complies with all HIPAA Privacy Guidelines.

_____ _____

Responsible Party Signature Date

## INSURANCE AUTHORIZATION

(Please allow us to make a copy of your insurance card.)

With my signature below, I authorize Lawrence Optometric Center (LOC) to disclose my protected health information and to act as my agent in helping obtain payment from my insurance company. Additionally, I authorize payment directly to LOC and I understand that **I AM RESPONSIBLE** for my bill regardless of whether or not it is paid by my insurance company. Finally, please be aware that LOC holds the right charge a $20 Administrative Fee for any delinquent accounts submitted for collection services.

I understand that the above is true and that this authorization is valid for one (1) year from the date of my signature. Additionally, I have the right to cancel this authorization at any time.

_____ _____

Responsible Party Signature Date

## MEDICARE AUTHORIZATION

(To be completed ONLY if your Primary Insurance is Medicare.)

I request that payment of authorized Medicare benefits be made on my behalf to Lawrence Optometric Center for services provided to me at this office. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the carrier as the full charge, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

This office has notified me that Medicare may deny payment of any non-covered services rendered on this date of service. If Medicare denies payment, I agree to be responsible for payment on all non-covered services or fees.

_____ _____

Responsible Party Signature Date

I **DO NOT** have health or vision insurance and accept full responsibility for all expenses incurred on today's visit:

| _____ | _____ | _____ |
|---|---|---|
| Responsible Party's Printed Name | Address | Daytime Phone # |
| _____ | _____ | |
| Responsible Party's Signature | City, State & ZIP | |