THANK YOU FOR CHOOSING CLEAR VIEW VISION CARE!

Welcome! We’re delighted to see you!

If you are new to our practice, I want to thank you for choosing us to take care of you and your family. It means a lot to us, and we will work hard to earn your trust and business. And if you are returning to see us again, may I take a moment to thank you? The biggest compliment our patients pay us is returning themselves and referring their friends, co-workers, and family we’ve yet to see. THANK YOU!

Now, we KNOW, nobody likes forms, but the information we collect is driven by:
1. Information we are required to collect by the federal and state government, even if you are self-pay
2. Information we are required to collect by your vision plan or medical insurance
3. Information that allows us to provide you the best care we can - we think this is the most important!

Please complete the forms attached, and bring them with you at the time of your exam. IT WILL SAVE YOU TIME in the office, and if you can, fax it to 520-327-8962 or email back to us at:

appointments@clearviewvisioncare.com

BUT STILL BRING YOUR PAPER COPIES! Here is the list for PEDATRIC PATIENTS:

REGISTRATION FORM—required for all patients
MEDICAL HISTORY—required for all patients
PEDIATRIC VISION HISTORY—required for all pediatric patients
NOTICE OF PRIVACY PRACTICES (NPP) —required to be given to all patients
INSURANCE AGREEMENT and NPP SIGNATURE FORM—required for all patients
HIPAA INFO AND CONSENT—required for all patients

AGREEMENT FOR CONTACT LENS FITTING —required ONLY for Current or New Contact Lens Wearers

Please also bring:
⇒ Any glasses/sunglasses currently used, and any boxes from contact lenses, ESPECIALLY if not from us
⇒ List of all medications (Rx and OTC)
⇒ Medical Insurance card and vision plan information
⇒ State or federal government issued PICTURE ID card—we are required by FEDERAL LAW to verify identity to bill any medical insurance or vision plans.

Thank you in advance.

Jeffrey F. Martin, OD, FAAO
PATIENT REGISTRATION FORMS

Please fill out the following information completely. We are asking for information required by the government, your medical insurance, and general information necessary to provide care for you. We **WILL NOT** under any circumstances sell your information to anyone or any entity. We may be required to share it with your insurance company. Refer to our HIPPA policy which further describes our policies.

Clear View Vision Care has incorporated a new state of the art communication system, in an effort to control rising costs and needless paper use. We will definitely need your E-mail and Cell phone numbers to facilitate contacting you by E-Mail and Text. Please feel free to ask us any questions you may have about this new, exciting program.

### PATIENT INFO

<table>
<thead>
<tr>
<th>Salutation</th>
<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
<th>Miss</th>
<th>Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffix</td>
<td>Jr.</td>
<td>Sr.</td>
<td>III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single</td>
<td>Married</td>
<td>Child</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Dob</td>
<td><em><strong><strong>/</strong></strong></em>/___________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSN#</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State ZIP</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home phone</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td>___________________________ ext_______</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pref. Phone</td>
<td>☐ home</td>
<td>☐ work</td>
<td>☐ cell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred language</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>___________________________ FT PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>___________________________ FT PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### GUARANTOR INFO - MUST MATCH INSURANCE CARDS

- ☐ Same as patient info  - ☐ Another person

<table>
<thead>
<tr>
<th>Salutation</th>
<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
<th>Miss</th>
<th>Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred name</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffix</td>
<td>Jr.</td>
<td>Sr.</td>
<td>III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single</td>
<td>Married</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to patient</td>
<td>☐ Father</td>
<td>☐ Mother</td>
<td>☐ Spouse</td>
<td>☐ Other</td>
<td></td>
</tr>
<tr>
<td>Dob</td>
<td><em><strong><strong>/</strong></strong></em>/___________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSN#</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State ZIP</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home phone</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td>___________________________ ext_______</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pref. Phone</td>
<td>☐ home</td>
<td>☐ work</td>
<td>☐ cell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>___________________________ FT PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>___________________________ FT PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Medical Doctor ________________________________
### Medical History

**Patient Name:** _____________________________  **Prior Name:** _____________________________  **DOB:** _____________________________

**Referring Physician**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Primary Care Physician**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

**What prompted your visit today?**

- [ ] Blurred vision
- [ ] Burning
- [ ] Itching
- [ ] Tearing
- [ ] Discharge
- [ ] Redness
- [ ] Eyestrain
- [ ] Eye pain
- [ ] Headache
- [ ] Night Glare
- [ ] Double vision
- [ ] Loss of vision
- [ ] Burning
- [ ] Dry eyes
- [ ] Gritty eyes
- [ ] Tearing
- [ ] Floaters
- [ ] Flashes
- [ ] Infection
- [ ] Distortions
- [ ] Something in Eye
- [ ] Sensitivity to light
- [ ] Poor night vision
- [ ] Other: _____________________________

**Have you ever been diagnosed with any of these eye conditions?**

- [ ] No Prior Eye Medical Problems
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Glaucoma
- [ ] Diabetic Retinopathy
- [ ] Dry Eye
- [ ] Infection
- [ ] Inflammation
- [ ] Allergy
- [ ] Floaters / flashes
- [ ] Iritis/Uveitis
- [ ] Retina defects / degenerations
- [ ] Other: _____________________________

**Family History of ANY Medical Eye Problems (other than glasses)?**

<table>
<thead>
<tr>
<th>Systemic Health History:</th>
<th>Patient</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any current or prior problems with the following systems?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Constitutional - e.g. fatigue, fever, headache, migraine</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Ears, Nose, Throat - e.g. congestion, hearing loss</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Neurological - e.g. numbness, tingling, dizziness, balance</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Psychiatric - e.g. change in mood or behavior, depression</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Heart - e.g. chest pain, heart murmurs, heart disease</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lungs, Breathing - e.g. wheezing, cough, asthma</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Gastrointestinal - e.g. nausea, constipation, liver</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Genital / Urinary - e.g. incontinence, difficult urination, ED</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Musculoskeletal - e.g. joint pain, history of fractures</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Integumentary / Skin - e.g. rashes, skin disorders</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Endocrine - e.g. diabetes, thyroid problems</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Bleeding / Lymph Problems - e.g. anemia, prolonged bleeding</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Allergy / Immunologic - e.g. asthma, chronic rashes, arthritis, Lupus</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Allergies to Medications?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Female Patients - Pregnant now?</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Alcohol use?**

- [ ] Yes
- [ ] No
- [ ] Occasionally
- [ ] 1/ day
- [ ] 2-3/ day
- [ ] 4+/ day

**Tobacco use?**

- [ ] Yes
- [ ] No
- [ ] Occasionally
- [ ] 1/2 pack/day
- [ ] 1 pack/day
- [ ] 1+ pack/day

**Recreational Drug use?**

- [ ] Yes
- [ ] No
- [ ] Occasionally
- [ ] Daily

**Reviewed:** _____________________________

Patient Signature (Parent if minor)
PEDIATRIC VISION HISTORY—WEIGHTED SYMPTOM CHECKLIST

Have you observed any of the following symptoms with yourself / the patient (and/or have they reported any of them to you)? Please mark the symptoms that occur frequently with two checks and those that occur occasionally with one check.

1. ___Skips lines while reading or copying
2. ___Loses place while reading or copying
3. ___Skips words while reading or copying
4. ___Substitutes words while reading or copying
5. ___Rereads words or lines
6. ___Reverses letters, numbers or words
7. ___Uses a finger or marker to keep place while reading/writing
8. ___Reads very slowly
9. ___Poor reading comprehension
10. ___Difficulty remembering what has been read
11. ___Holds head too close when reading/writing (within 7-8 in.)
12. ___Squints, closes, or covers one eye while reading
13. ___Unusual posture/head tilt when reading/writing
14. ___Headaches following intense reading/computer work
15. ___Eyes hurt or feel tired after completing a visual task
16. ___Feels unusually tired after completing a visual task
17. ___Double vision
18. ___Vision blurs at distance when looks up from near work
19. ___Letters or lines “run together” or words “jump” when reading
20. ___Print seems to move or go in and out of focus when reading
21. ___Poor spelling skills
22. ___Writing is crooked or poorly spaced
23. ___Misaligns letters or numbers
24. ___Makes errors copying
25. ___Difficulty tracking moving objects
26. ___Unusual clumsiness, poor coordination
27. ___Difficulty with sports involving good eye-hand coordination
28. ___Eye turns in or out
29. ___Sees more clearly with one eye than the other
30. ___Feels sleepy while reading
31. ___Visual perceptual or visual processing problems
   ___Difficulty with visual memory or visual sequencing
   ___Difficulty with visual-spatial concepts
   ___Directional confusion
   ___Impaired performance with copying
   ___Deficits in visual processing speed
32. ___Visual motor integration disorders
33. ___Non-Verbal Learning disorders
34. ___Performance scores not comparable to verbal scores
35. ___Dislikes tasks requiring sustained concentration
36. ___Avoids near tasks such as reading
37. ___Confuses right and left directions
38. ___Becomes restless when working at his/her desk
39. ___Tends to lose awareness of surroundings when concentrating
40. ___Must “feel” things to see them
41. ___Carsickness
42. ___Eyes bothered by light
43. ___Unusual blinking
44. ___Unusual eye rubbing
45. ___Dry eyes
46. ___Watery eyes
47. ___Red eyes

Scoring
Score 3 points each for items #1-34
Score 2 points each for items #35-41
Score 1 point each for items #42-47
Note: Score Double points for every item with two checks.

Criteria
15-20= Possible developmental vision problems.
20-30= Probable developmental vision problems.
Over 30= Definite developmental vision problems.
15+ points: Consult with a Developmental Optometrist.

TOTAL SCORE:
Notice of Privacy Practices for CLEAR VIEW VISION CARE, INC
Notice revised and effective September 23, 2013

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected health information (PHI) is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you. We will obtain your written authorization for uses and disclosures of your PHI that are not identified in this Notice or are not otherwise permitted by applicable law. You may revoke an authorization at any time by sending us a written request however we are unable to retract previous disclosures.

We May Use and Disclosure Your PHI WITHOUT Your Written Authorization For The Purpose Of:

• Treatment- Examples include scheduling and reminders of appointments; examinations, case management or care coordination; prescribing/ordering of glasses, contact lenses, vision aides or medications and notification of order status; or to recommend treatment alternatives or other health-related products or services.

• Payment-Examples include acquiring payment guarantor/insurance information; processing bills or claims; and collecting unpaid balances.

• Health Care Operations-Examples include financial or billing audits; internal quality assurance including patient satisfaction surveys; personnel decisions; participation in managed care plans; legal defense; business planning; and outside storage of our records.

Other Uses and Disclosures That Do NOT Require Written Authorization

• As Required by Law – we will disclose PHI when required to do so by federal, state or local law.

• Public Health Activities- for example contagious disease reporting, investigation or surveillance; and notices to and from the FDA regarding drugs or medical devices.

• Victims of Suspected Abuse, Neglect or Domestic Violence- PHI may be disclosed to the appropriate government authorities.

• Health Oversight Activities- such as audits, medical licensing, investigations, inspections or licensure.

• Judicial and Administrative Proceedings- such as in response to subpoenas or court orders

• Law Enforcement- such as disclosures about a suspected crime victim; to identify or locate a suspect, fugitive, material witness, or missing person; or about a crime committed in our office.

• Coroners, Medical Examiners and Funeral Directors- to identify a deceased person; to determine the cause of death or to allow funeral directors to carry out their duties.

• Organ and Tissue Donation- to facilitate organ, eye or tissue donation and transplantation, disclosures may be made to organizations that are involved in organ or tissue donation.

• Research - when approved by an institutional review or privacy board that has reviewed the research proposal and its privacy protocols. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

• To Avert a Serious Threat to Health or Safety- PHI may be disclosed to protect others and will only be made to someone who may help prevent the threat, including the target.

• Specialized Government Functions- such as the protection of the president or high ranking officials; lawful national intelligence activities; military purposes as required by military command authorities; the evaluation and health of members of the foreign service; in law enforcement custodial situations to provide health care or protect the health and safety of others.

• Workers’ Compensation- as required by law to workers’ compensation or similar authorized programs.

• Incidental Disclosures that are an unavoidable by-product of permitted uses or disclosures

• Disclosures to “Business Associates” and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA
Use and Disclosures of PHI to Family, Friends or Personal Representatives
Unless you object, we may share relevant PHI with your family, close friends or personal representatives who are involved in
your health care or payment of your health care. We may also notify them of your location or general condition. If you are not
present or are incapacitated, we may use or disclose relevant PHI when, in our professional judgment, it is in your best interest.

Specific Uses and Disclosures That REQUIRE Your Written Authorization
• Marketing Activities – other than face-to-face communications or promotional gifts of nominal value requires, we may
  not use or disclose your PHI for marketing of products or services without your written notification IF we receive payment
  by third parties whose products or services are described. The written authorization must inform you that we are receiving
  compensation.
• Sale of Health Information. We do not currently sell or plan to sell your health information and we must seek your
  written authorization prior to doing so.

Your Rights Regarding Your PHI:
• Right to Request Restrictions on Disclosures. You may send our office a written request to restrict or limit the PHI we use or
  disclose for treatment, payment, or health care operations or to limit the PHI we disclose to family members or friends involved
  in your care. We are not required to agree to all such requests. However, we must agree to requests to restrict disclosure of
  PHI to a health plan if the disclosure is for the purpose of carrying out payment or health care operations; if it is related to
  services that you have paid in full (e.g. out-of-pocket and without any third party contribution or billing); and is not otherwise
  required by law.
• Right to Receive Confidential Communication. You may request that we communicate with you about medical matters in a
  certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. Send a written
  request that specifies how or where you wish to be contacted to our office. We will accommodate reasonable requests.
• Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or
  payment for your care. This includes medical and billing records, other than psychotherapy notes. You may request a copy of
  your electronic health records in electronic format. All requests must be made in writing. Contact us for a copy of our
  authorization form. If copies of your records are requested, we may charge you a reasonable fee based on the cost of labor,
  supplies and mailing/delivery fees.
• Right to Amend. If you feel that PHI we have is incorrect or incomplete, you may send a written request, including the reason
  for the amendment, to our office.
• Right to an Accounting of Disclosures. You may request a list of certain disclosures of PHI, made within the past 6 years, for
  purposes other than treatment, payment and health care operations or for which you provided written authorization. Send a
  written request that includes the time period requested and how you would like the report delivered (paper or electronic) to our
  office.
• Right to a Paper Copy of This Notice. To obtain a paper copy of this notice send a written request to our office.

Our Duties
We are required by law to: maintain the privacy of your PHI, give you this Notice of our duties and privacy practices
regarding PHI information to notify affected individuals following a breach of their unsecured PHI and abide by the terms of the
Notice currently in effect. If you have any questions please contact our office.

Changes to This Notice: We reserve the right to change this Notice and make the new Notice provisions apply to PHI we
maintain. A copy of our current notice will be posted in our office and copies will be available by request.

Complaints: If you believe your privacy rights have been violated, you may submit a written complaint to our office or with the
Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Please direct any questions or requests to:

Jeffrey Martin, OD, FAAO
Clear View Vision Care
2233 E. Speedway Blvd
Tucson, AZ 85719
Ph: 520-327-9411
Fx: 520-327-8962
INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT / NPP ACKNOWLEDGEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. We regret this necessity, but the actions of a growing number of patients have required this step. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is YOUR Responsibility. Please read and indicate your acceptance of the below statements.

- I authorize Clear View Vision Care to release any records to expedite claims if my insurance requires it.
- I authorize Clear View Vision Care to bill my insurance company for services with payment made directly to them.
- Clear View Vision Care will make a good faith effort to verify my medical insurance coverage, vision benefits, and cost shares, but I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost responsibility is decided by my medical insurance or vision plan, which will not guarantee the information it provides until adjudicating the actual claim for my services, even if to deny it.
- I understand Clear View Vision Care is contracted as a “Specialist” office, and as such, the Specialist Level copy is due if applicable under my insurance. I understand any copays required by my insurance are due for every visit, at the visit. I will not ask for Clear View Vision Care to waive copays as this is fraudulent behavior under their insurance contracts and can be punishable under applicable law.
- Any copays collected are estimates, and are not the final adjunction of the amount due until my medical insurance or vision plan makes its final determination. If my medical insurance or vision plan renders a decision that is different, I am responsible for any unpaid balance, even if the claim is rejected or we are later notified that Clear View Vision Care is not on my plan, and will pay the difference promptly upon notice from Clear View Vision Care.
- I realize that if my insurance company fails to pay its anticipated balance in full or if payment is not made within 45 days of being billed, it is my responsibility to pay the doctor’s bill and pursue reimbursement from my insurer.
- I will pay collection fees, attorney’s fees, court costs, etc. for the purpose of collection on delinquent accounts. This will include a $35 fee to start collections plus 1.5% interest per month on accounts past due.
- In the event that I receive payment from my insurance company for services provided at Clear View Vision Care, I agree to endorse any received payment to Clear View Vision Care.
- I understand there may be medical findings, EVEN during a “ROUTINE” exam. I understand it is a VIOLATION of Clear View Vision Care’s provider agreement with BOTH my medical insurance and vision plan to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles. I also understand that Clear View Vision Care will not neglect medical findings in order to bill my vision wellness plan, as this would be a direct ethical violation for Clear View Vision Care.
- I understand I will be charged $35 fee for all returned checks.
- I understand I will be charged $50 for missed / broken appointments if I do not cancel 24 hours in advance.

I understand and agree to all statements above and understand this is a legally binding agreement.

Signature: ___________________________ Date ____________

NOTICE OF PRIVACY PRACTICES

By signing below, you attest that you have received this practice’s privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Signature ___________________________ Date ____________
The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text message, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. You consent and acknowledge agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Please sign and date below:

____________________________________  __________________________________________  ____/___/____
Print your name                               Signature (parent if minor)               Date
Agreement for Contact Lens Fitting or Annual Assessment at Clear View Vision Care

In order to determine an initial contact lens prescription or to renew your contact lens prescription, your doctor performs the following tests on a yearly basis. These procedures are not part of a standard eye exam and are not covered by your insurance under the routine / wellness eye exam benefits.

- Corneal topography- a digital color map of the surface of the cornea to monitor shape and curvature, which may be affected by contact lens wear.
- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues, to check contact lens wear suitability or for adverse effects from contact lens wear.
- Contact lens power determination to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions).
- Review new lens designs and materials that may improve comfort and/or health.

Follow-up services included and time period covered: Your fees for today’s service will include up to 3 visits, if needed, for prescription adjustments within 3 months from the date of the exam. Subsequent visits may incur fees for additional office visits. Any patient who fails to return during the 90 day period will incur additional fees for any care provided.

Medical complications: Any follow-up visit to evaluate medical complications of wearing contact lenses will be billed as medical office visits to either the medical insurance and/or the patient. They are not covered under this agreement.

All profession service fees are non-refundable: All service fees, including eye exam fees, contact lens evaluation fees, and medical service fees are non-refundable. All contact lenses are medical devices and require a valid fitting evaluation and prescription by an eye doctor, including non-prescription colored or theatrical lenses.

Expiration: All contact lens prescriptions expire after one year from the date of the initial contact lens fitting or annual assessment. Yearly examinations are needed to re-evaluate your contact lens prescription and the associated potential ocular health complications.

Standard Fees: Contact lens fee ranges from $90-$180 for most soft and rigid gas permeable contact lens wearers. The range depends on the complexity of your prescription and type of contact lens. Fees are due at the time of initial fitting or annual assessment. While you may have vision plan benefit that contribute to these fees, they will not cover them in full and you are responsible for the difference at the time of service.

Specialty, post-surgical, or medically necessary contact lenses: professional and materials fees will be substantially higher than the standard fees noted above, and will be discussed with you prior to payment.

IF YOU WISH TO PROCEED WITH INITIAL FITTING OR AN ANNUAL ASSEEMENET TO RENEW YOUR PRESCRIPTION, PLEASE SIGN TO BELOW TO INDICATE YOUR ACCEPTANCE AND UNDERSTANDING OF THESE POLICIES.

Patient name (Printed): _______________________________________

Signature (parent if minor): _____________________________________

Date : ________/_______/_______