Kent EYE CLINIC

Welcome!

Thank you for coming to see us and trusting us with your eyecare! Please take a moment to complete these forms and read this information carefully so we can ensure you receive the best care possible.

Insurance Billing and Payment Collection Policy

Comprehensive eye examinations will be billed to the patient's vision insurance policy if there is a routine diagnosis. In the event there is a medical diagnosis it will be billed to your medical insurance and subject to deductibles and co-insurance.

In the case of an emergency visit, if a medical diagnosis is made, or if a medical procedure is performed, then the examination or procedure will be billed to the patient's medical insurance. Medical claims may be subject to co-pays, co-insurance, and/or deductibles, even if they are technically "covered" by the patient's policy. If a deductible was not met at the time of service, the patient will be billed.

The patient is responsible for knowing and understanding their insurance coverage, and for ensuring we have current insurance information on-file. The patient is financially responsible for all charges not covered by their insurance policy, including any denied claims.
Patients without insurance will be given a 20% discount on examination and eyeglasses if payment is made in full at the time of service.

We will not engage in fraudulent or deceptive insurance billing practices including, but not limited to, altering service dates, billing insurance for non-prescription sunglasses when they are not covered, or applying one patient's benefits to another patient's services or materials.

All payments are due at the time of service/purchase. The patient has 60 days after their visit to pay their invoice in-full. If full payment is not received by the 60th day, a 1.0% finance charge will be applied to the invoice each month until full payment is received. A $25 fee is imposed for any returned checks.

Eyewear Ordering and Lab Service Policy

A restocking fee of 20% of the total Usual and Customary fees will be charged for all cancelations or returns. Clearance items, Elements packages, and custom made-to-order products, including customized Maui Jim or Oakley sunglasses, cannot be returned.

Because a variety of factors can impact the durability of an existing frame (including new frames purchased elsewhere), it is impossible to know how it will respond to adjustments or lens installation. While we will take every precaution when handling a frame, you understand that you are proceeding at your own risk, and we are not responsible for frame breakages during the lens installation process, fitting, or adjustments.

If you choose a lens material that is not impact resistant, such as Glass or CR-39 Plastic, then you acknowledge that we have warned you of the risk of serious injury from potential lens breakage, you agree to proceed at your own risk, and you agree to hold harmless Kent Eye Clinic, its doctors, and its staff should lens breakage result in injury. Impact resistant lenses, such as polycarbonate or Trivex, are mandatory for children and monocular patients.

Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement

I understand that, as part of my health care, Kent Eye Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments, and plans for future care and treatment. I understand that this information serves as: · A basis for planning my care and treatment.

- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party can verify that services were billed and provided.

I understand that I have the following rights and privileges per the Notice of Privacy Practices (this document is available upon request):

- This right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Kent Eye Clinic is not required to agree to these restrictions requested, and I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as a permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Kent Eye Clinic reserves the right to change their notice and practices, and prior to implementations, in accordance with Section 164.520 of the Code of Federal Regulations. Should Kent Eye Clinic change their notice, they will send a copy of any revised notice to the address I've provided (US Mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosures of my health information:

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I understand that, as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

By signing below, I indicate that I have read, understand, and agree to all of the terms and policies outlined above.

Patient/Parent/Guardian Signature	Date	Print Patient Name	Patient Date of Birth