OklahomaCityVision
FAMILY EYECARE & OPTICAL

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Authorization for Release of Information to Family Members

Patient Name_____Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Oklahoma City Vision to release my medical and/or billing information to the following individual(s) when requested:

1.)_____ Relationship_____ Date of Birth_____

2.)_____ Relationship_____ Date of Birth_____

3.)_____ Relationship_____ Date of Birth_____

4.)_____ Relationship_____ Date of Birth_____

Patient Information:
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:_____Date:_____

Welcome to Oklahoma City Vision

Thank you for choosing our office for your eyecare needs. We are pleased to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following important information. If you have any questions, please do not hesitate to ask.

❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. ❑He/Him ❑She/Her ❑They/Them ❑Male ❑Female ❑Other

First Name MI Last Name Preferred Name

Mailing Address (include any Apt #'s, Lot #'s or Suite #'s) City State Zip

( ) Home Phone ( ) Daytime Phone ( ) Cell Phone

E-mail Address Date of Birth Social Security Number

Employment Status: ❑Employed FT ❑Employed PT ❑Not Employed ❑Student ❑Retired

Employer Occupation

Marital Status:_____ How may we contact you? ❑Phone ❑E-mail ❑Text Message

Guarantor (Responsible Party) if the patient is a minor:

Full Name Relationship to Patient

( ) Daytime Phone Social Security Number Date of Birth

Payment is due at the time services are rendered. How are you planning on paying for today's services?
CASH / CHECK / CARE CREDIT / CREDIT CARD (Visa, MC, American Express, Discover, Flex, HRA)

Whom do we thank for referring you to our office?_____

If not referred by a patient, how did you hear about our office?_____

In order to file any insurance claims for you, we must copy ALL insurance cards at the time of your visit.

If we are filing insurance for you today, the following questions must be answered:

*Vision Insurance Name:*_____
*Medical Insurance Name:*_____ *If Medicare, is patient in hospice?* ❑*Yes* ❑*No*
*Additional Insurance Name:*_____

Policy Holder Information

Vision Ins. Policy Holder:_____ Medical Ins. Policy Holder:_____

Employer:_____ Employer:_____

SSN:_____ DOB:_____ SSN:_____ DOB:_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Oklahoma City Vision
Scott D. Forester, OD Trent J. Pitt, OD Joseph H. Phillips, OD, FAAO

Financial Policy

PAYMENT:
For all services, accessories, glasses or contact lenses ordered or provided by the physicians and staff of Oklahoma City Vision, payment is due at the time of service or when product is ordered. This includes your portion that insurance will not pay including any co-pay, deductible and/or co-insurance amounts. Medical records of any kind will not be released until the balance is paid in full.
The return check fee is $35.00 and will be added to your account balance.

INSURANCE:
At each visit to our office, we will ask you for a copy of all of your current insurance card(s) and if you have had any changes to your insurance. ***As a courtesy***, we will bill your insurance company for the services provided to you. However, it is ***your responsibility*** to know the benefits and conditions outlined in your insurance plan. Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. If for some reason your insurance company fails to pay, you will be expected to pay the balance in full within 45 days. If you ***have not*** met the deductible amount for the current year, and the insurance company applies your covered charges to your annual deductible, you will be billed for the amount of the service(s) and/or products. Payment will be required in full within 30 days of the date on your monthly statement. **If your insurance company requires an authorization or a referral, it is your responsibility to obtain it. You will be billed for all charges that are denied by your insurer due to no authorization or for us being out of network.** If insurance information, including copies of your cards, is not provided on the day of service, you will be responsible for filing the claim yourself.
By signing below, I authorize the release of any medical or other information necessary to process my insurance claims.

MEDICARE:
For patients who have Medicare, you must have **PART B** coverage for Medicare to pay your claim. You will be responsible for any charges Medicare or your supplemental insurance does not cover. This may include, but is not limited to: deductibles and refractions.

NON-INSURANCE:
For patients without insurance, payment is due at the time service is rendered.

PRODUCT:
A 50% deposit is due at the time materials are ordered. The remaining balance is due at the dispensing of materials. Deposits are non refundable and a late fee will be added to the balance after 45 days. After 90 days, our office is not responsible for product not picked up and will be disposed of. You will still be responsible for the balance on the account, including custom items based on your prescription and per your request. Non payment on the balance shall result in collection action. Our office and/or our labs cannot be held responsible for frame breakage when we re-use a patient's own frame or do adjustments to a frame not provided by our office.

RETURN POLICY:
In the event that you cancel an order for custom or ready made items (which would include all sunglasses, frames, complete set of glasses and/or specialty contact lenses) there will be no refund given. In a rare instance that you are unable to adapt to your new prescription, we would be happy to remake the lenses one time in a different design. No refunds will be issued for a less expensive design. The patient is responsible for any cost exceeding the original design.

CANCELLATION/NO SHOW FEE:
Any cancelled/missed/rescheduled appointment without at least a 24 hour notice will result in a $25 fee. It must be paid before rescheduling an appointment and is not covered by any insurance.

COLLECTIONS:
If your account is turned over to a collection agency, their fee is 30% of your account balance and will be added to the total.

LATE FEE:
A late fee of $25.00 will be added to your balance when the account is 45 days past due.

Thank you for taking the time to read our financial policy. We hope this answers any questions you may have. If you have any further questions, please do not hesitate to ask.

By signing below, I have read, understand, and agree to the conditions above.
I understand my information is protected by the HIPAA Privacy Statement.

Patient Signature (or Guardian if patient is a minor) Print Name Date

PLEASE COMPLETE BOTH SIDES

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Authorization for Email Communications Between Oklahoma City Vision and Patient

Secure electronic messaging is always preferred to unsecure email for more sensitive health and personal information, but under specific circumstances, unsecure email communication containing protected health information (PHI) and personal information may take place between Oklahoma City Vision and a patient.

This email communication may be used if both parties agree on this communication method and this form is completed and signed by the patient.

A copy of this form will be on file with Oklahoma City Vision and will be provided to the patient if requested. This agreement is limited to communications using the email address listed below.

Provider Awareness:

Standard email is not a secure means of communication, so as the provider Oklahoma City Vision will use the minimum necessary amount of protected health information when responding to your questions or communication information to you. In the event the communication requested is a copy of medical records, it may contain highly sensitive PHI such as information relating to HIV/AIDS, mental health or substance abuse.

Patient Awareness:

Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as fax or mail is always an alternative that is available to you.

By signing this form, you understand and are willing to accept the risks involved with insecure email communication of my protected health information. Examples of requested communication includes, but not limited to: copies of receipts, glasses or contact lens prescriptions, and/or copies of medical records.

Please note: This form only needs to be signed if you wish to receive emails that contain PHI. If you have provided us an email address on your patient paperwork, you may still receive emails concerning appointments. This authorization is only to inform you of the risks of sending information by email that may contain protected health information.

Patient's Name (please print):_____

Patient's Email Address (please print):_____

Family Members included in this authorization:_____

Patient's (or Guardian) Signature:_____ Date:_____