Eyes On You

Optometry

Cassandra Wood, O.D.

General Consent, Assignment of Benefits, Release of Information & Financial Policy

CONSENT TO TREATMENT:
By my signature below, I do hereby voluntarily consent to treatment by the optometrist, Cassandra Wood, O.D., of Eyes On You for an eye exam and to any related diagnostic procedures and treatments as necessary in the judgment of the optometrist. I acknowledge that eye exams are not always routine in nature, and at the discretion of my optometrist, my medical insurance may be billed accordingly.

INSURANCE BILLING/ASSIGNMENT OF BENEFITS:
By my signature below, I understand that Cassandra Wood, O.D., LLC, DBA Eyes On You will bill my insurance on my behalf to carriers which they are providers for. I understand that the practice cannot guarantee anything regarding my insurance, as it is a contract between me and the insurance company, not with the practice and my insurance company. The office will do its best to provide as much information as possible, but I understand it is my responsibility to know my insurance and benefits. I understand it is my responsibility to obtain any referrals or prior authorizations as necessary, and I am ultimately responsible for the payment of services rendered and any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage. Service fees and insurance coverage will try to be discussed prior to examination. I understand that all benefits quoted to me are not a guarantee of payment by my insurance and that final determination can only be made when the claim is processed. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance.

RELEASE OF INFORMATION & FINANCIAL POLICY:
By my signature below, I agree that all payments, co-payments, and /or deductible amounts due will be paid at the time services are rendered, unless payment arrangements have been made. I authorize payment of medical benefits directly to Cassandra Wood, O.D. for in-network services rendered and allow the release of any information necessary to obtain payment.

Office Policies

REFUNDS ON SERVICES RENDERED:
Professional fees, such as payments for exam fees or contact lens fitting fees, represent payments for services that were rendered (even if not successful) and are non-refundable.

EYEGLASS PRESCRIPTION CHANGES:
If you are not satisfied with your vision in your new glasses or contact lenses from a prescription obtained at Eyes On You, we will do everything within our power to improve it. Under this circumstance, a short office visit may be necessary to re-evaluate and recheck the prescription. If an Eyes On You Optometry prescription is filled elsewhere and you are not satisfied with your vision, we will gladly provide a prescription recheck visit within 60 days of your appointment. Recheck visits after 60 days will be charged a $25 refraction fee. If a change in prescription is needed, we will not be responsible for any charges incurred at another store. Most reputable optical dispensaries allow doctor Rx changes at no charge, but this is up to the patient to inquire about such policies in advance of making a purchase.
Progressive Lens Non-Adapt Policy: Progressive addition lenses (also called no-line bifocals) have a slight optical distortion in the outer portions of the lens, which can make some objects appear bowed or

curved, or can cause a feeling of motion when the head is turned. The reading zone of progressive lenses is wide enough for most purposes, but it may appear narrower than other bifocal styles. While most people are not bothered by these characteristics, some will find it unacceptable even after a consistent two-week adaptation period. If you cannot adapt to the progressive addition lenses, new lenses in a different design may need to be made. Any charges that incur will be subject to the store they were purchased from. If a doctor recheck is needed, we will honor a recheck within 60 days, and after 60 days a $20 refraction fee will be charged.

By my signature below, I agree to all of the consents and policies above while I am a patient of the practice.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care.

_____ / _____

Representative Signature Relationship to Patient