Eyexam of Peachtree City Office Policies

Please Read Before Signing

OCULAR HEALTH EVALUATION AGREEMENT

Optomap: The Optomap ultra-wide digital retinal imaging system captures more than 80% of your retina in one panoramic image. Traditional methods typically reveal only 10-15% of your retina at one time. The unique Optomap enhances your doctor's ability to detect even the earliest sign of disease that appears on your retina. The Optomap is a tremendous tool to help educate you about your eye health. This procedure is very simple, painless and it only takes a few minutes to perform with no side effects.

This procedure is recommended to be performed yearly and is not covered by insurance plans.
The cost of the Optomap is $35.

By initialing this section, I am consenting to have the Optomap as part of today's eye exam and I agree to pay the $35 fee for the Optomap.

INITIAL_____

FINANCIAL RESPONSIBILITY AGREEMENT

Insurances rarely cover in full the eye exam, contact lens evaluations, and medical visits. Our office staff will make every effort to verify your benefits, but verification of benefits is not a guarantee of payment.

Professional fees, such as exam fees and contact lens evaluations, represent payment for services and are non-refundable. An office visit to re-check a prescription will be provided at no charge within 30 days of the exam. Re-check visits after 30 days will be charged as an office visit. Follow-up visits for contact lens evaluations and fittings must be completed within 30 days of the initial exam. Any follow-up visits after 30 days will be charged as an office visit. Any re-checks or contact lens checks after 90 days is considered to be a new exam and the full exam fee will be charged.

I understand and agree that my co-payment, co-insurance, and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company, as well as, applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Eyexam of Peachtree City, P.C.

INITIAL_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

The privacy act established by the government to protect all your medical information requires us to inform you that your medical information is confidential and we can only release it upon your request. By initialing you are agreeing that you have been made aware of the Notice of Privacy Practices. The Notice of Privacy Practices is available upon request.

INITIAL_____

I _____ have read and understand the presented office policies.

Print Name

Signature _____ **Today's Date** _____/_____/_____