Name:

Financial Disclaimers:

Eligibility for medical insurance and/or routine vision benefits:
We will attempt to verify your plan eligibility for services and/or materials before your appointment. *Verification of eligibility as done as a courtesy only and is not a guarantee of payment.* Please check with your plan administrator if you have any questions regarding your eligibility. 20/twenty Optical only participates in select HMO plans.

_____
Initials

Liability:
I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay 20/twenty Optical. I also authorize 20/twenty Optical to release any information required for payment to be made. ***If my plan carrier does not pay, or partially pays, I understand that I am responsible for payment in full or the remaining balance.*** My signature below verifies that I understand this agreement and the above financial disclaimer.

_____

Date Signature

Refraction Fee
The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, Eyemed, Spectera, Avesis, Superior Vision, and Medicaid, your refraction is typically included in your exam benefits. Medical insurance that do not include routine vision benefits, including Medicare and select HMO and PPO, do not cover a refraction. The fee for the refraction is $30.00.*** My signature below verifies that I understand the refraction fee.

_____

Date Signature

Digital Retinal Imaging
The health of your eyes matters to you and it matters to us. During your comprehensive exam today we will be performing "DRI". Digital retinal imaging is a technology which involves capturing a high resolution digital image of the interior portion of your eye, the retina. Eye diseases such as diabetes, glaucoma, and age related macular degeneration can be detected much earlier. **This technology provides us with a digital retinal fingerprint and serves as a baseline for comparison at future visits. It is the gold standard for preventative care and disease management. Typically, insurance plans do not cover this annual $30.00 fee.**

_____

Date Signature

Method of Payment for Applicable Fees Today

_____ Cash _____ Personal Check _____ Credit Card _____ Care Credit

20/Twenty Optical
NOTICE OF PRIVACY PRACTICES

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.**

We are required by law to maintain the privacy of your health information and to give you notice of our legal duties and privacy practices with respect to your protected health information ("PHI"). This Notice summarizes our duties and your rights concerning your PHI. Our duties and your rights are set forth more fully in 45 C.F.R. part 164, and unless otherwise stated in this Notice, capitalized terms have the definition set forth in 45 C.F.R. part 164. We are required to abide by the terms of our Notice.

Uses And Disclosures of Information That We May Make Without Written Authorization

We may use or disclose your PHI for the following purposes without your written authorization. These examples are not meant to be exhaustive; not all of these situations will apply to us; some may never come up at our office at all.

- **Treatment.** We may use or disclose PHI to provide treatment to you. For example, our doctors and staff may use information in your medical records to diagnose or treat your condition. Also, we may disclose your information to health care providers outside our practice so that they may help treat you.

- **Payment.** We may use or disclose PHI so that we, or other health care providers, may obtain payment for treatment provided to you. For example, we may disclose information from your medical records to your health insurance company to obtain pre-authorization for treatment or submit a claim for payment.

- **Health Care Operations.** We may use or disclose PHI for certain health care operations that are necessary to run our practice and ensure that our patients receive quality care. For example, we may use information from your medical records to review the performance of physicians and staff, train staff, or make business decisions affecting our practice and its services.

- **Required By Law.** We may use or disclose PHI to the extent it is required by law.

- **Threat to Health or Safety.** We may use or disclose PHI to avert a serious threat to your health or safety or the health and safety of others.

- **Abuse or Neglect.** We must disclose PHI to the appropriate government agency if we believe it is related to child abuse or neglect, or if we believe that you have been a victim of abuse, neglect or domestic violence.

- **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Contact identified below. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Practices Covered By This Notice

This Notice of Privacy Practices applies to the practices of 20/Twenty Optical at the following locations, their departments and units wherever located; their employees, staff, and other practice personnel; and volunteers whom we allow to help you while you are in our practice:

- 20/Twenty Optical

  2020 Blue Messa Court

  Loveland, CO 80538

This Notice of Privacy Practices also applies to physicians and other members of the medical staff who have agreed to abide by its terms concerning the services they perform on behalf of the practice locations listed above.

Privacy Contact

If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please call or write to the practice location you visit using the information listed above.

Acknowledgement of Receipt

By signing below, you agree that you have read and understood this Notice, and that you have received a paper or electronic copy of this Notice.

Signed: _____

Print Name: _____

Date: _____