PATIENT PRIVACY CONSENT FORM

I, ____, give my expressed permission to share my health information with the following:

1. ______________________________________ 3.______________________________________

2. ______________________________________ 4. ______________________________________

Note: Under NO circumstances will we provide anyone not listed above ANY information from Appalachian Eye Care without your consent. *You may add or remove names at any time.*

I wish to be called at [_] Home, [_] Cell, [_] Other (check **all** that apply) regarding my care/follow up.

The best phone numbers to reach me are:
Home_________________________,Cell_________________________,Other_____________________

[_] I DO [_] I DO NOT : give my permission to leave relevant medical information on my voice mail.

[_] I DO [_] I DO NOT : want relevant information shared with person who may answer the phone.

[_] I have reviewed the Appalachian Eye Care Notice of Privacy Practices and understand that I may request a copy at the front desk or may review the policy at www.mountaineyes.com

Policies and Procedures

APPOINTMENTS AND REFERRALS: There will be a $25 charge for any missed appointments without a 24 hour notice. I am also aware that after 3 missed appointments I may also be released as a patient for failure to keep my health assessment updated. I acknowledge that if the medical staff of Appalachian Eye Care refers me to another physician or specialist for treatment of a specific health issue, I must comply with this appointment. Failure to do so may result in being released as a patient.

SELF PAY/NON PARTICIPATING INSURANCE POLICY: Appalachian Eye Care does not participate with all insurance companies. It is your responsibility as a patient/guardian of a patient to know which physicians are participating providers with your medical insurance policy. You can contact your insurance company for that information. If your insurance requires a referral, it is your responsibility to ensure that we have received that referral prior to your scheduled appointment. If we have not received your referral prior to your appointment, you will be responsible for the full amount of any charges not covered by your insurance.

Examples of insurances that we **do not** participate with include, but are not limited to: Avesis, Block Vision, Davis, NVA, Optima, Spectera/Optum Health, and Virginia Medicaid; as well as some plans of Carelink Medicaid, Coventry Care of WV, and Unicare. As non-participating physicians, we do not have a contract with these particular insurance companies. This means that your insurance company may not pay for any medical charges or may pay at a reduced rate for services that are rendered at Appalachian Eye Care. Payment, in full, is due at the date of service.

With very few exceptions, we will file your medical insurance claim on your behalf with your current insurance company. If your insurance company pays any portion of your claim, even though we are a non-participating provider, you will be reimbursed any monies due to you when our billing department receives that insurance payment.

By signing below, I understand that if Appalachian Eye Care is a non-participating provider with my particular medical insurance, or I am a self-pay patient; I am responsible for all or a percentage of any services rendered by Appalachian Eye Care.

PAST DUE ACCOUNTS: Payments not received upon the date of medical services or statement date, will be considered delinquent, and interest at a rate of 20% will accrue until the balance is resolved. You further agree to be financially responsible for any collection cost associated with the balance recovery due our office, i.e. collection agency fees; attorney fees; court cost; and/or certified mailing cost. Any personal check declined by your banking institute will result in a $25 charge, allowable under West Virginia law, plus any bank fee incurred. Should civil litigation be required to necessitate the collection of any delinquent amounts or to resolve any disputes, you agree to the following court venue: Mercer County, WV. By providing your cell phone as a means of contact and communication, you hereby authorize our office and our business associates to also communicate with you at this number. This would include, but not limit to, communication from our collection agency, and/or collection attorney. You understand that you may incur an expense during cell phone communication.

MEDICARE AND PRIVATE INSURANCE REGULATION CHANGES: When you are seen for a regularly scheduled eye exam and need to have special testing or procedures done, it may be done in a separate appointment on a separate date. Testing and procedures may have additional charges depending on your insurance coverage plan.

FRAME AND SPECTACLE LENS POLICY: All glasses are custom made and therefore, cancellations, changes and/or cash refunds are not permitted. At the doctor's discretion, patients who are not satisfied with their vision in their new glasses will have the prescription adjusted at no additional cost within 60 days. For patients who are not satisfied with their vision through new glasses that were purchased elsewhere, there will be a $50 fee to see the doctor. Please ask the opticians for details regarding warranty information as every custom order is different.

CONTACT LENS POLICY: Contact lens exams include follow up care for 60 days for all contact related visits. After 60 days, there will be a $20 fee per office visit. Rigid gas permeable contact lenses must be returned within 60 days from the date they were ordered if an adjustment is necessary. Opened boxes of soft contact lenses cannot be returned.

BY SIGNING BELOW, I ACKNOWLEDGE AND CONSENT TO THE ABOVE POLICIES AND PROCEDURES OF APPALACHIAN EYE CARE:

Patient Signature ______________________________ Date__________

Patient Printed Name ______________________________