**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The **OPTOMAP**® Retinal Exam:

* Provides us with a scan of the retina to confirm the health of your eye
* Allows our doctors to detect the presence of disease early in its progression
* Will be saved in your medical file enabling your doctor to make important comparisons during your annual eye exam
* **May not require dilating drops which result in blurred vision and sensitivity to light for 2-4 hours**. Some patients will need to have their eyes dilated also.

The fee for the **opto**map® retinal exam is **$43** and is not covered by your insurance.

Dr. Ansley, Dr. Hill, Dr. Kentros, and Dr. Duty recommend you have this test done at your annual exam.

 I have read and understand the above and **agree** to the **opto**map® Retinal Exam.

 I have read and understand the above and **decline** the **opto**map® Retinal Exam

**Financial Policy:**  We have contracts with many insurance companies to accept assignment of benefits for our services. Payment in full will be required unless insurance benefits to cover expenses can be verified prior to rendering services. You are responsible for knowing your insurance coverage and benefits. Your co-pay and deductibles will be collected at the time of your visit. We accept Cash, Visa, MasterCard, American Express, Discover and Checks. As a service to you we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles and co-insurance. Payment is due upon receipt of your statement**. \_\_\_\_\_\_** **Initial here**.

I request that payment of Medicare / Other Insurance Benefits be made to Inverness Eye Care, for services provided. I hereby consent to the treatment for myself or the above listed patient. I authorize the release of any information needed for processing this or any related claim/s. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I hereby accept financial responsibility for all charges and understand insurance will be billed as a courtesy. All unpaid balances will be charged a 1.5 percent rebilling fee assessed monthly. All returned items will be assessed a $30.00 fee in accordance with State of Alabama law 13.A-9-13.1. \_\_\_\_\_\_\_\_ **Initial Here**

**“No-Show” Policy:** Our physicians and staff work hard to meet the needs of our patients. We kindly ask that you give 24-hour notice if you need to cancel or reschedule your appointment. A onetime consideration will be made for failure to show up for your appointment. Any subsequent **“no-shows” will result in a $50.00 fee** which must be paid prior to another appointment being scheduled. Thank you for your understanding in this matter. **\_\_\_\_\_\_\_**  **Initial Here**

**AUTHORIZATION AND CONSENT TO TRANSMIT APPOINTMENT REMINDERS VIA UNSECURED INTERNET AND TEXT MESSAGING**

I request, authorize, direct permit and unequivocally consent to Inverness Eye Care transmitting my appointment reminders, to include the date and time and location to me. I expressly and unequivocally acknowledge that Inverness Eye Care does not have the capability to respond to my electronic mail transmissions through encrypted or otherwise secured Internet connections or text messaging. I expressly and unequivocally waive and claims or rights with respect to transmission of ePHI or PHI via the unsecured internet. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Inverness Eye Care or any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my appointment information as a result of transmission via the unsecured internet or text messaging. I intend to be legally bound hereby. \_\_\_\_\_\_ **Initial Here**

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_