4800 S. Hulen St.
Suite #2720
Fort Worth, TX 76132
infocusvisionstaff@gmail.com
PHONE#: (817) 346-2186
FAX#: (817) 370-7902

InFocusVision
we focus on you

305 W. FM 1382
#524B
Cedar Hill, TX 75104
infocusvisionch@gmail.com
PHONE#: (972) 293-7170
FAX#: (972) 293-8421

CONSENTS

PATIENT RESPONSIBILITIES:

As part of standard office procedure, the staff at **InFocus Vision** makes every effort possible to bill patients' exams to health/vision insurance. All insurance coverage must be pre-approved prior to examination. **In the case coverage cannot be verified, all charges must be paid in full when services are rendered.**

If you are ineligible for insurance benefits or denied coverage by your insurance, your initial/signature below indicates that you agree to full financial responsibility for any outstanding balance(s). Additionally, your signature below indicates a compliance to forward any monies reimbursed to you by insurance to **InFocus Vision** within **14 business days**.

If you are having trouble adapting to your new glasses, **you have up to 30 days** from your original exam date to return for a prescription re-check. **After this 30 day grace period, re-check appointments will incur a $25 office visit fee.**

_____
PLEASE INITIAL HERE

Patients requesting a reprint of their prescription after their initial exam will incur a small fee. (physical copy/emailed/faxed)

HIPAA/PRIVACY ACKNOWLEDGE & RECEIPT OF NOTICE OF PRIVACY PRACTICES:

As required by law, **InFocus Vision** makes every effort to maintain confidentiality and to provide patients with notice of legal duties and privacy practices with respect to protected health information (PHI). By initialing, I acknowledge that copies of **InFocus Vision's Notice of Privacy Practices** has been made available to me for my records.

_____
PLEASE INITIAL HERE

FEE FOR MISSED APPOINTMENTS:

Due to the high demand of appointments, our staff at **InFocus Vision** makes every effort to accommodate our patients' medical needs. Please be courteous, and call promptly if you are unable to keep your appointment, as there are always patients waiting and wanting to be seen as soon as possible.

If you are unable to keep your scheduled appointment, our office requires a 24 hour notice. **A charge of $25 will be incurred for every appointment missed without proper notification as outlined above.**

_____
PLEASE INITIAL HERE

AUTHORIZATION TO RELEASE INFORMATION (OPTIONAL):

On behalf of myself as a patient or as the patient's parent/legal guardian, I authorize **InFocus Vision**. and staff to discuss health information from medical records, as specified below:

_____ _____
PLEASE PRINT NAME OF AUTHORIZED INDIVIDUAL | **RELATIONSHIP TO PATIENT**

ANNUAL APPOINTMENT REMINDERS:

As part of our efforts to maximize patient care, at **InFocus Vision**, patients may opt into our "pre-appointment" system to avoid running out of contacts, missing out on insurance benefits, etc.

□ **Yes! Please remind me, and schedule a tentative appointment for my annual exam.**
□ **No, thank you. I would like to opt out of the pre-appointment system at this time.**

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COMMUNICATION PREFERENCES: Please indicate your preferred method(s) of contact below, as applicable.

□ **TEXT/CELL** _____

□ **EMAIL** _____

□**HOME PHONE** _____

□**UPDATE ADDRESS** _____

ADVANCED BENEFICIARY NOTICE:

- I hereby authorize **InFocus Vision** to bill my insurance company for services provided to me. I allow payments made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- As a courtesy to our patients, **InFocus Vision** makes considerable effort to verify insurance coverage, from each patient's insurance representative, and provide an **estimate** of what it **may** pay. This is only an estimation and not legally binding.
- If, in the event, my insurance **does not** cover all services rendered during my visit, I am solely responsible for the balance remaining on my account. It is my responsibility, as the patient, to pay all monies owed to **InFocus Vision** for all services rendered to me within **90 days.**
- If necessary, my account will be placed with a collection agency and I agree to pay the costs associated with the collection agency fees.

Please be advised that you will need to make decisions about a variety of healthcare services that may or may not be covered by insurance, including (but not limited to) services such as:

Medical/Office Visits	**Optomap Screening**
Preventative Care	**OCT Screening**
Contact Lens Fittings	**Diagnostic Testing**

The office of InFocus Vision makes every effort to advise and inform patients of their coverage prior to examination. In the case of non-coverage, patients may be required (or may choose) to submit a receipt to their insurance provider for later reimbursement.

By signing below, I indicate my consent to full financial responsibility for the cost of services rendered to me. I affirm that I have reviewed, understand, and agree to comply with the policies and procedures as specified. I have read and understand that this is a legally-binding agreement.

PATIENT NAME: _____ **TODAY'S DATE:** _____

PLEASE PRINT **MM / DD / YY**

SIGNATURE _____

PATIENT OR PARENT/GUARDIAN SIGNATURE