CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Midwest Eye Centers. Treatment provided by medical providers, nurses, and medical assistants at Midwest Eye Centers may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Midwest Eye Centers. I understand that all supplies, medical devices and other goods provided to Patient are provided by Midwest Eye Centers AS IS and Midwest Eye Centers disclaims any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities are available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Midwest Eye Centers.

Communicable Disease Testing: I agree that if a Midwest Eye Centers employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to law, Midwest Eye Centers may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Midwest Eye Centers may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Midwest Eye Centers can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN.

Accessing Pharmacy Information: I agree that if a Midwest Eye Centers employee or provider needs to access my pharmacy information that they have my permission to do so.

 Patient's Initials: ______

Alternative Contact/Preferred Method of Communication Form

Patient Name: ___________________________ Date of Birth: _________________

We at Midwest Eye Centers take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak with only an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do NOT authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employee of this clinic to speak with:

1. Person: _______________________________ Relationship: ______________________

   Phone Number: ________________________

   ☐ Appointments and Account/Bill ☐ Medical Care and Treatment (including Test Results and Lab Results)

2. Person: _______________________________ Relationship: ______________________

   Phone Number: ________________________

   ☐ Appointments and Account/Bill ☐ Medical Care and Treatment (including Test Results and Lab Results)

3. Person: _______________________________ Relationship: ______________________

   Phone Number: ________________________

   ☐ Appointments and Account/Bill ☐ Medical Care and Treatment (including Test Results and Lab Results)

Please check your primary and secondary preferred methods of communication:

____ Home Phone/Answering Machine ___ Mail ___ Work Phone
____ Cell Phone (voicemail) Cellphone Text Message
____ E-mail and E-mail Address ____

Electronic Communication is my preferred method ___Yes ___No
(In order to electronically communicate with you or anyone you designate, we are required to have your written permission.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

 Patient's Initials: ______

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Midwest Eye Centers, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive that the appointed time. If you are unable to keep your appointment, please give at least 24 hours notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a $35 fee per patient.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we

retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (ie, SSI, disability, etc.).

4. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination.

5. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $35 and will be added to your account for each bounced check.

6. OTHER INSURANCE: I understand that Midwest Eye Centers participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Midwest Eye Centers if I belong to a plan with which Midwest Eye Centers does not participate.

7. NON-COVERED SERVICES: I understand that Midwest Eye Centers contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan.** The undersigned agrees to cooperate with Midwest Eye Centers to obtain necessary health care service plan authorizations.

8. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Midwest Eye Centers, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Midwest Eye Centers for payment. I understand and agree that if my account is delinquent, I may be charged interest of 1.5% (one and one-half percent) per month, 18% (eighteen percent) per year. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees of 33.3% (thirty-three and one-third percent) of the balance due, whether or not suit is filed. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Midwest Eye Centers. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Midwest Eye Centers. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

The physicians and staff at Midwest Eye Centers appreciate your confidence in allowing us to participate in your eye care.

Patient's Initials: ______

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME: ____

PATIENT'S DATE OF BIRTH: ____

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ___________ TIME: ________________