Eye Center
of St. Augustine

Authorizations

- I hereby authorize and request the medical treatment necessary for the care of the above patient.

- I authorize Eye Center of St. Augustine to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.

- I acknowledge full financial responsibility for services rendered at Eye Center of St. Augustine. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.

- I further authorize and request that insurance payments be made directly to Eye Center of St. Augustine if they elect such an arrangement.

- I acknowledge my email may be used solely to relay information regarding appointments or other general information.

- Patients, patient representatives, or visitors that elect to record an exam visit hereby acknowledge and accept among other risks, that the recordings may not provide the opportunity for a third party to pose questions to the provider/staff and that certain nonverbal communications may not be captured by the recording.

- Patients, patient representatives, or visitors that elect to record an exam visit hereby acknowledge and accept among other risks, that the recordings may not provide the opportunity for a third party to pose questions to the provider/staff and that certain nonverbal communications may not be captured by the recording.
  Under no circumstances may a patient, patient representative, or visitor take a Recording of another patient, patient representative, or visitor without explicit permission.

- ** ***This policy is not applicable to patients, patient representatives, or visitors in (California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, Pennsylvania, and Washington). In these states, undisclosed recordings, on the part of physicians or patients, are prohibited by law, as everyone being recorded must consent.***

- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.

☐ I have read and fully understand the above consent for treatment, for the release of protected health information, for financial responsibility, and for insurance authorization.

_____ _____

Patient / Parent or Guardian Signature Date

Eye Center
of St. Augustine

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____Date of Birth:_____

This form **does not** apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies. We cannot release **ANY** of your medical information to any person or organization (including family members, spouse, etc) unless you list their names below.

I give permission to Eye Center of St. Augustine to discuss the following medical and billing information about me **(check all that apply):**

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnosis, medications and treatment plan)
- ☐ Laboratory/Test Results
- ☐ **Financial Details/Payment Information**
- ☐ All of the above
- ☐ Other: _____

Eye Center of St. Augustine has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to Eye Center of St. Augustine.

- ☐ This authorization expires: _____ - unless revoked or terminated **in writing** by you or your patient personal representative.
- ☐ No expiration date
- ☐ I decline permission to discuss medical information

_____

Signature of Patient/Guardian Date Relationship to Patient

_____

Staff Member Date

Eye Center
of St. Augustine

Notice of Privacy Practices Acknowledgement Form

I acknowledge that I have received a copy of the Notice of Privacy Practices for Eye Center of St. Augustine. I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operation purposes.

_____ _____

Signature of Patient or personal representative with appropriate legal authority Date

If signed by a Personal Representative:

_____ _____

Name Relationship to Patient

--- OFFICE USE ONLY ---

If the Patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgment could not be obtained.

Notice of Privacy Practices given to the individual on _____(date) **by:** _____

- ☐ Face to face meeting
- ☐ Other: _____

Reason Individual or Personal Representative did not sign this form:

- ☐ Patient or Personal Representative chose not to sign
- ☐ Other: _____

Eye Center
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Patients' Rights and Responsibilities

Eye Center of St. Augustine recognizes that a personal relationship between the physician and the patient is essential for the provision of proper medical ophthalmic care. The traditional physician-patient relationship takes on a new dimension when the care is rendered within an organizational structure such as Eye Center of St. Augustine. These guidelines help Eye Center of St. Augustine assure optimal patient care and greater satisfaction for the patient, his or her physician, and our facility. Therefore, Eye Center of St. Augustine is informing you of your rights and responsibilities in seeking care from our physicians at our facilities. Get to know our physicians and more about Eye Center of St. Augustine at: www.eyecenterstaug.com

Your Patient Rights

You have the right to:

- Be treated with respect, consideration, and dignity.
- Be free of all forms of abuse, neglect, or harassment.
- Receive care in a safe setting.
- Be provided with appropriate personal privacy.
- Expect privacy of health information: all disclosures and records to be treated confidentially, and, except when required by law, be given the opportunity to approve or refuse their release.
- Be provided, to the degree known, complete information concerning your diagnosis, evaluation, and treatment, alternative treatments and appropriate preventative measures, risks and benefits of treatment, and your prognosis; in appropriate understandable language. When it is medically inadvisable and/or the patient is unable to understand such information, the information is provided to a person designated by the patient as legally authorized (a patient representative or surrogate). Depending on the designation the patient has made, the patient's representative or surrogate may make all healthcare decisions for the patient during his/her surgery center visit, or may act in a more limited role, for example, as a liaison between the patient and the surgery center to help the patient communicate, understand, remember, and cope with the interactions that take place during the visit, and explain any instructions to the patient that are delivered by the surgery center staff. If a patient is unable to fully communicate directly with the surgery center staff, then the surgery center may give the patient's rights information to the patient's representative or surrogate. If the patient is judged incompetent by a court, the appropriate representative has rights to exercise on behalf of the patient.
- Be given the opportunity to have all your questions answered promptly to your satisfaction in an appropriate, understandable language.
- Be given the opportunity to participate in decisions involving your ophthalmic care, except when participation is contraindicated for medical reasons.
- To voice grievances regarding treatment that is or fails to be furnished with methods of expressing/filing grievances, complaints, and suggestions to the organization including those required by State and federal regulations.

- To have all violations/grievances reported immediately to the practice and/or surgery center manager relating, but not limited to; mistreatment, neglect verbal, mental, sexual, or physical abuse. Substantiated allegations must be reported to State or local authority.
- Be informed as to:
    - These patient rights
    - Expected conduct and responsibilities
    - Services available in the organization
    - Provisions for after-hours and emergency care
    - Fees for services and payment policies
    - The right to refuse participation in experimental research
    - The credentials of your healthcare providers upon request
    - Any facility advanced directives
    - Description and availability of applicable State health
    - Safety laws and State advanced directives brochures/information
- Know by name the physician responsible for coordinating your care.
- Change your healthcare provider if you choose and if other qualified providers are available.
- Receive from your physician full information necessary to give informed consent prior to the start of any operative or invasive procedure. Except in emergencies, such information for informed consent should include, but not be limited to, the specific procedure and/or treatment, medically significant risks involved, the probable duration of incapacitation, the benefits of the treatment in appropriate understandable language.
- Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning the medical alternatives, the patient will receive such information. (i.e. Informed Consent).
- Have all Eye Center of St. Augustine services made available to persons with disabilities.
- Decline treatment after being informed of the possible consequences of such a decision. Your decision will be respected to the extent permissible by law.
- Refuse examination or observation by any person not directly responsible for your care.
- Receive instructions regarding your care after you leave the facility.
- Receive an explanation of your doctor and facility bills.
- Notification of physician's financial interest/ownership.
- A second opinion or referral.

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Your Patient Responsibilities

Your responsibilities are to:

- Inform Eye Center of St. Augustine of your need for interpretation services prior to appointment.
- Arrive as scheduled for appointments and notify Eye Center of St. Augustine in advance of canceled appointments. Provide accurate and complete information, to the best of your ability, about your medical history, medications (including over the counter products and dietary supplements), any allergies or sensitivities to medications and other items, current health concerns, and current eye concerns.
- Ask sufficient questions to ensure understanding of your illness or problem, as well as your provider's recommendations for continuing care.
- Follow the agreed-upon treatment plans prescribed by your doctors and other health professionals working under your doctor's direction, and participate in your care.
- Either carry out treatment and educational recommendations or accept responsibility for the outcome.
- Question any and all instructions you do not understand.
- Communicate with your health care provider if your condition does not follow the expected outcome.
- Provide a responsible adult to remain in the surgery center during surgery, to transport you home from the facility, and remain with you for 24 hours, if required by your provider or indicated on discharge instructions.
- Inform the facility of any medical power of attorney, living will, or other directive that could affect your care.
- Become informed of service costs and the requirements of your medical/vision insurance coverage such as: required referrals, co-payments, deductibles, and your out-of-pocket responsibilities.
- Make payment or arrange for payment of services accepting personal financial responsibility for any charges not covered by your insurance.
- Behave respectfully toward all the health care professionals and staff, as well as other patients and visitors.
- Maintain a healthy lifestyle.

Eye Center of St. Augustine Contact Information for complaints and grievances:

Practice Administrator, Samantha Crunden
Eye Center of St. Augustine
1400 US Highway 1 South, St. Augustine, FL 32084
Phone: (904) 829-2286
Fax: (904) 679-3727

Website to contact the Office of Medicare Beneficiary Ombudsman:
https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare beneficiaries: The Ombudsman's role is ensure that you receive this information and helps you understand your Medicare options and your Medicare rights and protection.

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Financial Policy

Missed Appointment Policy

Eye Center of St. Augustine is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice it may prevent another patient from being seen. Kindly provide 24-hour notice to cancel an appointment. If prior notice is not given, you may be charged $25 for the missed appointment.

Refraction Fee

A refraction is a test that is used to determine any optical defect present in the eye. A refraction is necessary for a prescription for best corrective lenses, a determination of the progression or diagnosis of certain ocular conditions, and/ or a determination for the basis of your visual complaints. Refractions are not always covered by insurance, and you may be responsible for the $30 fee at the time of service. Refractions are never covered by Medicare.

Routine vs. Medical Coverage

Office visits may be categorized as either "routine" or "medical". A comprehensive "routine" vision exam may contain the same elements as a comprehensive "medical" eye exam. The type of eye exam you have is determined by the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Routine vision exams typically produce diagnoses such as nearsightedness or astigmatism, while medical eye exams may produce diagnoses such as glaucoma or conjunctivitis. Please verify your routine and medical coverage with your insurance company.

Contact Lens Fitting Fees

A contact lens fitting determines the contact lenses safely fit on your eyes and which lenses provide the best vision, comfort, and health for your eyes; the design and selection of lenses; and follow-up visits up to eight weeks. After wearing contacts for a period, your doctor will require a re-examination at least once a year to verify that your prescription is still appropriate and healthy for your eyes. Most of the time, medical insurance does not pay for these services though some vision plans do provide partial coverage for contact lens services. Our fitting fees for disposable contact lenses range from $95.00 to $250.00, depending on specific needs/complicity. Renewal and refitting fees for disposable contact lenses range from $40.00 to $175.00. Contact lens fitting fees are due at the time of service. No contact lenses will be dispensed prior to the payment of these fees.

☐ I have read and understand the policies listed above.

_____ _____

Patient / Parent or Guardian Signature Date