Eye Specialists of Colorado

Better Vision for a Better Life

Financial and Consents Policies

_____ I authorize Eye Specialists of Colorado to bill my medical and/or vision insurance carrier, any remaining responsibility (co-insurance, deductibles, etc.) I agree to pay out of pocket. Insurance co-payments are mandated by your insurance company and **MUST** be paid at the time of service and will be collected at the end of your visit. I agree that if my insurance company, Medicare, and/or Medicaid denies benefits for any reason, I will be responsible for the full amount owed for the services provided during the visit.

_____ I would like to have a Refraction today, so that I may obtain a copy of my glasses prescription. The cost for the refraction is $60 and we will bill your medical and/or vision insurance. **I understand that this may or may not be covered by my medical insurance, including Medicare and Medicaid.** In the event this cost is not covered, I understand I will be billed for this amount and will be required to pay it in full.

_____ I authorize Eye Specialists of Colorado to utilize telemedicine, when mutually agreed upon. This enables health care providers at a different location from the patient to share medical information for the purpose of improving access to patient care. This may include live two-way audio and video, patient medical records, medical images, and output data from medical devices and sound and video files for the purpose of diagnosis, therapy, follow up and/or education. The laws that protect privacy and the confidentiality of medical information (HIPAA) also apply to telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that no results from the use of telemedicine can be guaranteed or
assured.

_____ In the event the doctor determines I need to have my eyes dilated in order to determine or verify a diagnosis, I agree to have my eyes dilated. **Dilation can blur vision for a period of 2-6 hours and I am responsible for my own safety while driving and/or walking.** If you wish to delay the dilation in the exam, you can return at a later date for that portion of the exam with a driver.

Signature _____ Date _____

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Cancellations, Delays, and No-Shows

We understand that there are times when you may miss an appointment due to emergencies, weather, and/or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If it is necessary to cancel or reschedule a scheduled appointment, we require that you call and/or leave a message at least 24 hours prior to your scheduled appointment.**

We understand that delays can happen, however, we try to keep the other patients and the doctor on time. I you are running late, please notify the office. **I understand that if I am 15 minutes past my scheduled time, I will have to reschedule my appointment.**

"No Show" refers to any patient who fails to arrive for a scheduled appointment. I understand that if I "no-show" for an appointment or do not cancel 24 hours in advance, I will be subject to a $100 fee. I understand that in the event of three (3) documented "no - shows" and/or missed appointments, the practice has the latitude to terminate further care from Eye Specialists of Colorado. If this happens, you will receive a letter from our office confirming this decision.

Signature _____ Date _____