NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED

As a member of a vision care program or medical insurance plan, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision plan carrier or medical insurance carrier denies or does not cover my claim for these services.

I acknowledge that the reason for my appointment from my perspective will determine whether the visit will be billed to my vision plan carrier or medical insurance carrier. Vision care plans cover routine exams to check for prescription changes, screen for disease or update eyeglasses or contact lenses. Medical insurance plans will be billed for exams for medical care, evaluation of a complaint or to follow an existing condition.

MEDICAL NECESSITY

If my medical insurance determines that a medical service and/or materials are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAY's

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or VitalEyes.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that Iam also required to make payment for at least 50% of materials at the time materials are ordered. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided access to a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

AGREEMENT

_____	_____	_____
Date	Patient/Guarantor Signature	Print Patient Name