Please read the following carefully and INITIAL each section.

Notice of Privacy Practices Acknowledgement

_____ By initialing I acknowledge the full notice of privacy practices of Gallatin Valley Vision, LLC is available by request from our check in desk. I have read (or had the opportunity to read if I so chose) and understand the notice.
Is there anyone, besides yourself, that we may discuss your medical information with? If yes, please list:

_____

Assignment of Release of Insurance

_____ By initialing I certify that I, and/or my dependent(s) have coverage with the insurance company indicated in the patient profile and assign directly to Dr. Jessica N. Lemons all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. Claims will be filed by HCFA or electronically.

Financial Policy

_____ Fees are standard and based on the complexity of your visit. Payment in full is required at the completion of your exam and can be made with cash, personal check, credit card and/or care credit. All sales are considered final. Insurance co-payments are due at the time of service. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled. Custom orders are non-refundable. In store credit may be offered on some orders. All orders must have at least a 50% payment made at the time the order is placed. Any remaining balance must be paid before the order can be dispensed.

The following services are elective: you may choose BOTH, NEITHER, or EITHER. BOTH services are recommended by the doctor. If you have elected no and the doctor feels it is necessary, this will be discussed during your exam.

Dilation Consent

Our doctor uses eye drops to dilate your pupils as part of a comprehensive eye evaluation. There is no additional fee for this service. Pupil dilation allows the doctor to better view key structures of the eye, to determine if you have any disease that may affect your vision. These drops typically cause decreased reading vision and light sensitivity for about 3-4 hours. Usually, distance vision is minimally affected.

_____ Yes, I consent to having my eyes dilated today.

_____ No, I decline to be dilated. I understand that certain medical conditions that may affect my vision may not be detected by my refusal and I accept all risks and responsibility.

Digital Retinal Imaging Consent

Retinal imaging allows instant viewing of the back of the eye without pupil dilation to monitor the eye for change. While taking the retinal photo does not replace the need to have your eyes dilated, it is strongly recommended that you have photos taken if you plan on declining dilation at today's visit. **This is a screening tool. The fee for this service will be $40.**

_____ Yes, please perform the Digital Retinal Imaging.

_____ No, I do not wish to have the optional imaging performed.

Your signature indicates you understand and agree to all the terms & conditions contained in the above paragraphs.

Patient Name: _____Authorized Signature: _____

Date: _____Relationship to Patient: _____