**In an effort to increase transparency, we ask you to review our policies**

**(Init.) \_\_\_\_\_ Optomap Digital Eye Scan:** I have been educated regarding its benefits and cost ($45.00)

Please check one for Digital Eye Scan: *Accept:* ***\_\_\_\_\_*** *Decline:* ***\_\_\_\_\_***

**(Init.) \_\_\_\_\_Consent for treatment:** I/We hereby authorize Juanita Vision Clinic to administer diagnostic and eye medical procedures as may be necessary for proper health care.

**(Init.) \_\_\_\_\_ Authorization to release information:** I/We hereby authorize Juanita Vision Clinic to release any medical or incidental information that may be necessary for medical benefits or in processing of applications for financial benefits. This includes but is not limited to my insurance company,

 rehabilitation services, social security administration and worker’s compensation.

**(Init.)\_\_\_\_\_ Office Policy on payment:** I understand that I am responsible for payment of all charges. As a courtesy, my primary insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company within 90 days of my insurance company’s response to my claim. I authorize insurance benefits to be paid directly to my provider. I understand my insurance benefits as quoted to me at the beginning of this visit as only an estimate. My balance will be estimated and collected at the end of my visit today including deductible and co insurance if applicable.

**(Init.) \_\_\_\_\_HIPPA:** I acknowledge that I have been offered a copy of Juanita Vision Clinic’s Notice of Privacy

 Policies.

**(Init.)** **\_\_\_\_\_Electronic Notications:** Juanita Vision clinic utilizes electronic appointment reminders and notifcations. Please tell the front office if you DO NOT wish to receive electronic notifications.

 **(Init.)** **\_\_\_\_\_Contact Lens Services:** I acknowledge that I have read and understand Juanita Vision Clinic’s policies about contact lens evaluation and the fees associated. I understand that I have a 90-day time period while trying out contact lenses to have my contact lens prescription finalized or to return to clinic for contact lens follow up appointments. I understand that all contact lens refit request/follow-ups after 90-days from the initial contact lens exam date are subject to additional fees

**Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_**

If any information has changed please update below:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If signing for a minor, please indicate relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list those individuals and their relationship to you with whom we may communicate exam results:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name/Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

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