I acknowledge receipt of the Notice of Privacy Practices from the office of Dr Mark J Roy, III – Vision Source:

____________________________________ print patient name ______________date

____________________________________ patient or guardian's signature

__________________________ print guardian's name ___________relation to patient

YOUR PRIVACY IS PROTECTED! THE FOLLOWING INFORMATION IS NEVER SHARED WITH OTHERS WITHOUT YOUR CONSENT:

We need to communicate with you from time to time regarding appointments, status of glasses / contact lens orders, payment information, and new optical products, services, or technologies that may be of benefit to you. Please complete the following and indicate how you prefer to be contacted by numbering your preferences (1=first or best contact, 7=least preferred contact):

Preference	Communication	Address, number, or e-mail
____	US Postal Mail	___________________________address
		________________________city, state, zip
____	Home Phone	________ - _________________
____	Work Phone	________ - _________________
____	Cell Phone	________ - _________________
____	Text Message to Cell Phone Listed Above	
____	e-mail ______________@ ________________ . _______	
____	other (alternate phone, etc.) ____________________________________	

THANK YOU FOR CHOOSING DR. ROY'S OFFICE!!!

Vision Source

Thibodaux Vision Center Mark J Roy, III, OD

Financial Policy

We are dedicated to providing the best possible care and service, and regard the understanding of our financial policies as an essential element of care and treatment. To assist, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

INSURANCE COVERAGE

It is your responsibility to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also your responsibility to know whether your visit with us is covered by your insurance plan fully, partially, or not at all and whether your plan requires a referral from your primary physician before your visit. **For example, you may be covered under your primary healthcare plan for additional vision care services under a different carrier. It is your responsibility to know whether you have this separate coverage.** If at the time of service you only notify us of your primary healthcare plan and later make us aware of additional coverage under another plan, you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is 100% accurate only if you obtain it directly from your health plan, not from our office staff. **In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of the services provided. Initial_______**

ROUTINE AND MEDICAL EYE EXAMS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with **no eye problems**. If the doctor detects any medical condition, (dry eyes, floaters, etc.) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the exam on your visit, the doctor may ask you to return another day for a medical eye exam. **Please note that some insurance plans consider a routine eye exam to be a non-covered service.**

Vision Plan Patients: I have read and understand the above routine eye care policy. **Initial_______**

SPECTACLE AND CONTACT LENS EXAMS

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We will be happy to submit this charge to your insurance company. However, if this charge is determined to be a "non-covered" service, you will be responsible for this charge. If your vision plan offers a contact lens material benefit, the cost of the exam will be deducted from this benefit. **Initial______**

AMOUNTS DUE FROM THE PATIENT

We gladly accept cash, personal checks, care credit, and most major credit cards. **Insurance co-payments will be collected at the time of service**. If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. The insurance is then responsible for reimbursing you. If using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed, it must be paid in full before glasses and/or contacts will be dispensed. **Initial_______**

AMOUNTS DETERMINED "NOT COVERED"

In the event a health plan determines a service of ours to be "not covered," you will then be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in eyeglasses prescription and/or contact lens prescription (a procedure called refraction). We charge for this service and **many** insurances, including Medicare, deem this service "not covered." **If we check your eyes for a change in glasses, you are personally responsible for this charge. If you do not desire a refraction, please inform our office staff. Please note that some insurance plans consider a routine eye exam to be a non-covered service. Initial_______**

I have read and understand the financial policies of Thibodaux Vision Center, Inc. and also understand that Thibodaux Vision Center, Inc. reserves the right to change any and all fees at any time.

_______________________________________ _______________________

Signature of Patient (or Responsible Party if Patient is a Minor) Date

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Print Name of Patient & Date of Birth PLEASE PRINT LEGIBILITY