Medical Release, Lifetime Signature, Payment Authorization and HIPPA Acknowledgement

Patient Name: Mr. Mrs. Dr. _____

Street:_____ **Phone:**_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:____/____/____ **Email:**_____

Language:_____ **Race:**_____ **Ethnicity (Hispanic or Latino):**_____

Occupation:_____ **Employer:**_____

Primary Medical Insurance:_____ **Secondary Medical Insurance:**_____

Vision Insurance:_____ **Primary Medical Physician:**_____

Note: ***There are two types of insurances that may help pay for your eye care service and products. You may have both, and our practice does accept both.***

- **Vision Care Plans,** such as Eyemed and VSP
- **Medical Plans**, such as Medicare, BC/BS and Aetna

Vision Care Plans cover only routine vision exams, along with eyeglasses and contact lenses. These plans do not cover diagnosis, management, or treatment of eye diseases.

Medical Plans must be used if you have an eye health problem or systemic problem that has ocular complications. The doctor will determine if these conditions apply to you. Many medical plans, such as Medicare, do not cover refraction, or the determination of a prescription for eyeglasses. This charge, as well as any other "non-covered" services and co-payments will be the responsibility of the patient.

For our Contact Lens Patients:

All contact lens fitting evaluations and services are additional to the comprehensive examination. There is a separate fee associated with any contact lens evaluation. This fee also includes six months of contact lens related follow-up care. The fee will vary with the complexity of the fitting, and may or may not be covered in full by your insurance. Applicable co-pays will apply.

I hereby give my consent for me or my child to be seen by the doctors. I understand that my eyes may be dilated during examinations. I acknowledge that I have read and agree to the Privacy Policy (HIPAA), and I also authorize the office **Dale Stein and Associates, O.D., P.C** to share my demographic information with **Lenscrafters** for the purpose of sending annual examination recall notices, and that copies of these policies are available upon request. I also authorize payment and/or insurance benefits for services rendered by Dale Stein and Associates, O.D., P.C. be made payable to this office. ***I also understand that I am responsible for any non-covered service, co-payments, and deductibles.***

Signature:_____ **Date:**_____