

Riviera Opticare Inc. Conditions of Service and Office Policies

MEDICAL CONSENT TO TREATMENT: Riviera Opticare Inc. doctors are licensed to provide both Routine Eye Exams and Medical Eye Exams. Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings, or a condition found during the course of the exam, the Doctor may find it necessary to move from a Routine Exam to a Medical Exam as well as order additional tests. The Doctor will notify you during the course of the exam when they determine a Medical Exam is required. When the Medical Exam is required, be advised it is not a covered item under your Routine Eye Exam benefits through your Vision Insurance Plan. Medical Exams are billed through your Major Medical Carrier and are subject to their specific Copays, Deductibles, and Co-Insurance, which will be due at the time of service. In the event I do not wish the Doctor to proceed with the Medical Examination, I understand it is my responsibility to immediately inform the Doctor so that he/she can refer me out to the appropriate Doctor or Specialist.

FINANCIAL ACKNOWLEDGMENTS: I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits to go directly to Riviera Opticare Inc. I authorize Riviera Opticare Inc. to deposit checks received on my account made out to me for services rendered. **I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges.** In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest at the rate of 1.5% per month. 18% per year, collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and other costs the court determines proper. **Authorization obtained at time of service does not guarantee payment and any denied services balance will be billed to the patient.**

CONSENT TO TREATMENT: I hereby consent to any routine procedures, medical treatment or facility services rendered to the patient under the general and special instructions from the attending Optometrist.

CHECK AGREEMENT: I hereby agree to pay a service charge of \$25.00 for each check or other instrument tendered by me but returned to Riviera Opticare Inc. I further agree to pay all costs and expenses, including attorney's fees, which are incurred in collection on such a returned check, draft, or money order.

MEDICARE/MEDICAID PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me released to the Social Security Administration or its intermediaries or carriers any information needed to process any claim on this or any related service. I request that payment of authorized benefits be made in my behalf directly to Riviera Opticare Inc. for its charges and for any charges of Physicians for whom the facility is authorized to bill in connection with its services. We expect Medicare will not pay for the refraction. I hereby agree to pay for this service.

TRICARE/TRIWEST AUTHORIZATION: I request payment of authorized benefits to this facility on my behalf for services furnished to me by this facility including Optometrists' services I authorized to bill in connection with its services.

RECEIPT AND ACKNOWLEDGMENT OF HIPAA NOTICE: I hereby declare that I have read and understand the facility's Policy of Privacy Practices.

RELEASE OF INFORMATION: I hereby authorize Riviera Opticare Inc. to release to my insurance company any information concerning the procedures performed during this treatment and the final diagnosis, as well as information contained on this form.

RELEASE OF ACCOUNT INFORMATION: I understand any individual listed on this page and any individual who can be reasonably assumed to will be authorized to retrieve any and all information pertaining to this account. This can include, but is not limited to, medical information relating to any person listed on the account as well as financial information and transactions. Furthermore, if there are individuals whom I do not want authorized to access information, I will notify the facility HIPAA Compliance Officer in writing.

★ **CONTACT LENS FEES:** I understand that contact lenses require additional testing and Professional fees that range from \$79 - \$295. Medical condition or specialty lens designs range from \$149 - \$400. **INITIALS:** _____

MINOR PATIENTS: We require that an adult (parent or legal guardian) accompany a minor patient. The adult accompanying the minor is required to pay in accordance with our policies. We do not accept third part assignments nor do we recognize or enforce the terms of divorce decrees.

I HAVE READ AND UNDERSTAND THESE POLICIES AND AGREE TO ABIDE BY THE TERMS.

Names listed here are authorized to access my records and account information: 1) _____

2) _____

3) _____



Signature: _____

Date: _____