Financial Policy Statement

Thank you for choosing Riverview Eye Care for your eye care needs. We are so delighted to have you as a patient. At Riverview Eye Care we are committed to providing the highest quality of eye care. In order to better assist you, we kindly ask you review and sign this Financial Policy Statement.

Required Information & Patient Responsibility

We require all patients to complete the Medical History and Information forms, sign the Notices of Privacy Practices (HIPPA acknowledgement) and provide complete insurance information prior to seeing the doctors. We are only able to bill your insurance plan(s) if we are provided with accurate and completed information. In some cases a signed and dated claim form may be required. If you are unable to provide us with complete information prior to your visit, any charges for services and/or materials will be your responsibility.

Please note that all co-pays or co-insurance will be collected when services are rendered. If a claim is denied (either in full or a portion) by your insurance plan, you will be responsible for any charges that were not covered. If you are currently covered by a plan not accepted by Riverview Eye Care, you will be responsible for any charges for services and/or materials rendered.

_____X If you are doing a contact lens exam or are here for an office visit, you have 30 days from your original exam to have necessary follow ups and see the doctor(s) at no charge. After 30 days, an extra charge will incur for additional follow ups.

_____X You have 30 days from the date of purchase to exchange any Un-Opened and Un-Marked boxes of contact lenses for credit.

HIPAA

In accordance to the law we are required to keep health information private and protected at all time. Please see the attached form titled “Notice of Privacy Practices,” for our entire privacy policy. Any personal or medical information given to our office will only be used to provide the highest and most personalized eye care possible. Information will not be released to any other party without your signed consent. You may request a full written copy of our Notice of Privacy Practices. Please see the front desk staff for a copy and/or more information.

PATIENT DILATION CONSENT FORM

In order to provide the most comprehensive exam possible we request that all of our patients have a dilated eye exam. Dilation of the pupil (temporarily making the pupil larger) is a common diagnostic procedure used by eye doctors to allow for a more thorough examination of the eye. Without dilation, our doctors cannot fully assess the health of the eye which can result in permanent and irreversible vision loss. To dilate the pupil, eye drops must be administered. Dilation drops typically require half an hour to fully take effect and takes up to 6 hours to wear off. Common side effects include: sensitivity to light and difficulty focusing on near objects. Please exercise caution.

YES_____ I understand the risks and benefits of pupil dilation and I consent to have the procedure performed.

NO _____ The risks and benefits of pupil dilation have been comprehensively explained. I understand these risks and benefits, but I do not wish to undergo the procedure.

I hereby agree that I understand and acknowledge my patient responsibilities and by signing below I agree to comply with all the terms stated above.

X_____ Date_____

Signature of patient/guardian or responsible party