ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Spring Klein Vision Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ **I have read or had explained** to me Spring Klein Vision Center's Notice of Privacy Practices and **agree to continue** my care with Spring Klein Vision Center under said terms.
- ☐ **I have read or had explained** to me Spring Klein Vision Center's Notice of Privacy Practices and **do not wish to continue** my care with Spring Klein Vision Center under said terms.
- ☐ The Notice of Privacy Practices **could not be read** due to the emergent nature of the care of other reason described as

_____

_____

I hereby authorize Spring Klein Vision Center to release the following information contained in my medical record:

- ☐ Contact Lens Prescription & Spectacle Prescription
- ☐ Most Recent Examination Record
- ☐ Billing Information
- ☐ The Complete Record

I prefer the above information to be shared as requested with the following person(s):

_____

_____
Name(s) and Relationship to Patient

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNINGIT VOLUNTARILY.

_____ _____
Print Patient's Name Date

_____ _____
Signature of Patient/Legal Guardian Relationship to Patient

SPRING KLEIN
VISION CENTER

Please Circle: Mr. Mrs. Ms. Rev. Dr.

Last Name _____ First Name _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ SS# _____

Please check the phone number that you would prefer as your primary number:

- ❑ Home # : _____
- ❑ Cell # : _____
- ❑ Work # : _____

Email Address: _____

Medical Insurance Primary's Name: _____ DOB: _____

Vision Insurance Primary's Name: _____ DOB: _____

Primary's Employer: _____

Primary's SS # : _____

Primary's Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact/Relationship: _____

Emergency Phone # : _____

How did you hear about us? _____

We assure you that we will use your Social Security Number for Insurance purposes ONLY. Please be sure to read the HIPAA page that is attached and sign below. Thank you!

X _____ Date: _____

SPRING KLEIN
VISION CENTER

Assignment of Benefits

This form is consent from the patient or guardian to allow Spring Klein Vision Center to file benefits on your behalf. Please note that some services rendered may not be covered by your insurance provider.

I agree that I have been informed that the Optomap is **NOT** covered by any insurance at this time.

Initial: _____

I hereby authorize ***Spring Klein Vision Center*** to file my vision and/or medical benefits on my behalf, and therefore, I authorize my insurance carrier to direct payment of benefits to:

Spring Klein Vision Center

6603 FM 2920

Spring, TX 77379

Initial: _____

I agree to assume responsibility for full payment pending any remaining balance that is not covered by my Insurance Carrier.

If you have additional questions that we were unable to answer please refer back to your Insurance Carrier or your benefit packet.

_____

Print Patient's Name

_____ _____

Patient/Guardian Signature **Date**

SPRING KLEIN
VISION CENTER

Contact Lens Evaluation Fees

We want to inform you and help you to understand what is involved with a contact lens fitting. If you have any questions, please do not hesitate to ask! Whether you are trying contact lenses for the first time, or you currently wear contacts, you will need to have a contact lens evaluation in order to obtain a new or updated prescription to order more lenses for the year.
A contact lens evaluation is a separate examination performed only after a complete ophthalmic exam for glasses has been performed. This contact lens evaluation is a valuable and necessary step in determining the contact lens power and parameters. It must be performed on all contact lens wearers (new and previous wearers) to insure that your contact lenses will provide the best overall vision and to insure the safety and health of your eyes while wearing these medical devices throughout the year. On the day of your examination, if needed and time permitting, an optical technician will instruct you on insertion and removal of the lenses. If this is not possible, you will be given a return appointment to meet with one of the technicians for this instruction session. After receiving these instructions, you will wear the lenses for one to two weeks and return for a follow-up examination to adjust the prescription and fitting parameters of the lens if needed. Once the final parameters are determined, **you will receive a prescription** which authorizes you to purchase a 12 month supply of those lenses.* If you are a previous wearer and no changes are being made to the fit or power of your lenses, either Dr. Way or Dr. Nelson will still need to re-evaluate the fit and vision with your contact lenses; however, you will not be required to go through the one week "trial" phase of your contact lenses and you will be given your updated prescription on the day of your examination.
Below are the categories of Fitting Fees. Your fees will be determined by the optometrist, are **due at the time of the fitting** and are **non-refundable.** If you decide to "up-grade" to a different category (i.e. monovision to multifocals) after the initial visit, additional fees may be added. Fees do not include the price of the contact lenses.

Fitting Fees are as follows:
("New contact lens wearer" applies to patients new to our practice or first-time contact lens wearers)

Renewal of contact lens fit and power: Single Vision or Monovision (This revalidates your prescription for one year.) **$52.00**

Renewal of contact lens fit and power: Multifocal or Specialty (This revalidates your prescription for one year.) **$72.00**

New contact lens wearer: Single Vision or Monovision (This includes the insertion/removal teach and follow-up.) **$57.00**

New contact lens wearer: Multifocal or Specialty (This includes the insertion/removal teach and follow-up.) **$77.00**

Contact lens brand modification: not covered by insurance (This applies if the prescription is changed after 3 months from the initial exam date.) **$25.00**

Contact lens prescription modification: not covered by insurance (This applies if the prescription is changed after 3 months from the initial exam date.) **$40.00**

NOTICE: Fitting fees cover up to the first three months from the initial fitting date. If you do not report any issues within the three months, an additional fee may apply for any changes thereafter.
Most insurances will not cover BOTH contact lenses and glasses. If you choose to use your benefits for glasses, the evaluation fee and purchase of contact lenses will be additional. Please check with your insurance or with one of our staff members if you have questions about your insurance benefits.
The price of contact lenses will vary depending on type and prescription. Some types of contacts are not available in complimentary diagnostic lenses, i.e. gas perms, custom planned replacement or daily wear soft lenses. In these cases, diagnostic lenses will be ordered and the fitting will be scheduled at the time that we receive them. Diagnostic contacts are available for evaluation purposes only, and are not available for individual purchase. Contact lens orders normally take 3-5 business days to arrive, and can only be placed once payment is received, (please plan accordingly). If any changes are made, we can only exchange unopened boxes that have not been tampered with. **The fitting fee will not be refunded or credited.**
I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all of my questions answered.

Signature of patient or legal guardian Date

*Texas state law does not require you to purchase your lenses from the prescribing doctor but it does require that you provide for reimbursement for the separate contact lens evaluation prior to receiving the prescription.