Receipt of Notice of Privacy Practices & Consent Form

San Ramon Family Optometry is committed to caring for our patient's complete ocular health. Our patients will receive a complete eye health examination. The doctors here are trained to diagnose and treat most ocular diseases.
As a courtesy to our patients, we are happy to file with your insurance company. However, the patient is responsible for any co-pays and/or deductibles which your insurance requires.

Routine Vision exams will be filed with a patient's Vision Plan if you have one. A routine exam means there is not a medical diagnosis. A routine diagnosis is myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, and/or presbyopia.
If a *Medical Diagnosis* (cataracts, glaucoma, diabetes, pink eye--conjunctivitis, etc.) is determined by the doctor, the exam is no longer routine, but medical. This means we will bill your Medical (Health) Insurance. We request a copy of your medical card for these reasons.
I have read and understand when my Vision Plan will be billed and when my Medical Insurance will be billed by San Ramon Family Optometry. I also understand not all services are covered by insurance, and I will be responsible for the charge if my insurance denies a service. **Initial here**: _____

By signing this acknowledgment of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have received, read, and understand the Notice of Privacy Practices for review on the date identified below.
I understand that this Location, San Ramon Family Optometry, may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, communication of exam reminders or information about services/ products provided by the Location).
I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and authorize this Location to submit my vision benefit claims, and any pertinent information related to this claim, to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I receive from this Location. I further agree to assume responsibility of full payment pending any remaining balance not covered.
I also understand that: 1) *prescription checks three months after date of exam are subject to a refraction fee or contact lens re-fit fee,* 2) *if a contact lens fitting process is not completed within three months of the original fitting date, there will be a re-fit fee,* 3) *there is no refund for examination or contact lens fitting fees or copayments.*

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Patient Signature or Patient's Legal Representative Date