# Jamesburg Family Eyecare

Thank you for choosing our office as your healthcare provider. We pride ourselves on providing exceptional patient care. We understand that you have options when choosing your eye care professional. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

## General Consent to Treat

I, the undersigned, authorize Jamesburg Family Eyecare, its agents, associates and physicians to provide medical services. This includes but is not limited to examination, treatment, and performance of diagnostic tests and procedures that are necessary for the diagnosis and treatment of medical conditions according to the judgment of the treating provider.

## Insurance Coverage

We will submit insurance claims as a courtesy to you. **INSURANCE CO-PAYMENTS AND FEES FOR NON-COVERED SERVICES ARE ALWAYS DUE AT THE TIME OF SERVICE.** Most insurance companies have limitations. Your insurance policy is a contract between YOU and the insurance company. While we can look up insurance coverage for you, it is NOT our responsibility to know your specific insurance plan. If you have questions about copays, refunds, exchanges, etc. from an insurance laboratory, YOU must call the insurance company. Additionally, all insurance copays including copays for exam services and lens upgrades ARE NON-REFUNDABLE. There is a ONE TIME redo within 30 days.

*Health insurance (such as Medicare, Blue Cross, etc.) may cover your exam and other services if you are having a problem with your eyes. There is usually a copay associated with such a visit. This copayment is charged EVERY time a new visit occurs.*

*Vision insurance (VSP, Eyemed, Davis, etc.) will cover routine eye exams for glasses, contact lenses, etc. when there is no specific problem. Again there are copays associated with each service.*

## Eyewear

We require **FULL** payment on all orders. All eyewear is **CUSTOM ordered** and **cannot be refunded or exchanged.** Furthermore, once an order is placed it **cannot be canceled**. If changes need to be made after the order has been placed, there may be an extra fee to make such changes. **THERE ARE NO REFUNDS OR EXCHANGES ON ORDERS, INCLUDING ORDERS PLACED THROUGH AN INSURANCE LABORATORY**.**There is a ONE-TIME remake offered free of charge within 30 days of ordering.**

Downgrading from a more expensive lens type to a cheaper one does NOT mean any co-pays or fees will be refunded.

## Refraction

This is a test to determine the prescription of your glasses. Although it is an important part of a comprehensive eye exam, some health plans (including Medicare) do not cover it. Our fee for this service is $20.

## Frame Warranty

If a frame proves defective, it can be replaced ONE TIME within 365 days of your original order. It is at the discretion of the manufacturer what is considered defective. There is a **$50 shipping and handling fee**. If your frame brakes, do not use any type of glue as this will void the warranty. Bring the frame to our office for repair or replacement. Nose pads are not covered by warranty.

## Spectacle Lens Guarantee

If you are not satisfied with your glasses, we will gladly re-check your prescription and remake your lenses **ONE TIME within 30 days of your original order** into the lens of your choice that is of equal or lesser value at no additional cost.

## Pick Up Policy

Eyeglasses and contact lenses not claimed within 30 days will be subject to forfeit of the deposit and will be returned to the manufacturer.

## Financial Responsibility

Patients are responsible for any and all co-payments, coinsurance, deductibles, and all charges not covered by their insurance. Additionally, patients are responsible for additional fees, such as fees for insufficient checks/closed accounts, collection costs if an account is sent to collections, charges for copying and distributing patient medical records; fees for completing the form and fees for missed appointments. There is a **$5 fee** for EACH prescription ordered after the initial free prescription has already been provided. There is also a **$5 fee** for EACH additional set of contact lenses a patient wishes to try after an initial TWO set has already been provided during the fitting exam.

## Acknowledgement of Notice of Privacy Practices

I understand that Jamesburg Eye Care is required by law to maintain the privacy of protected health information and to provide individuals with notices about their legal duties and privacy practices and patient rights with respect to protected health information. I acknowledge that I have been given the option to receive and/or review the Jamesburg Family Eyecare Notice of Privacy Practices. If I have questions, I can speak to a staff member.

## Photo/Face ID Images

Copies of photo identification taken by our office will be considered part of the patient's medical record and will be used for identification purposes.

## Email Waiver

To comply with HIPAA regulations; If you wish to receive or send regular unencrypted (non-secure) EMAIL, you must sign the waiver below:

I, _____, request Magdalena Spiewak OD to send me a copy of my prescription and/or itemized receipts. I understand that emails sent to me may contain health information. Additionally, I understand that these emails and attachments are NOT secure and may be viewed by others. I agree to hold harmless Dr. Spiewak, her officers, agents, employees and contracted healthcare providers from any and all liability, loss, damage, cost or expense incurred through the transmission of unencrypted email.

I would like all emails to be sent to

_____@_____

Signature _____ DATE: _____

## Missed Appointment

If you cannot come to your appointment, please let us know **48 hours in advance.** If you do not notify us of your change of plans, then we must charge you a **FEE of $50**. Missed appointments and subsequent unpaid fees may result in the patient being discharged from the practice. Additionally, anyone arriving more than **10 MINUTES late** for an appointment may be forced to reschedule.

Thank you for understanding our policies. If you have any questions please do not hesitate to ask.

**I have read and understand the above policies.**

_____

**PRINT PATIENT'S NAME AND DATE**

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**SIGNATURE OF PATIENT OR GUARDIAN**