BOEVER
FAMILY EYECARE

PATIENT ACKNOWLEDGEMENT

Payment & Billing Terms, HIPAA and Authorization Notification

SECTION A: PAYMENT & BILLING

Please take a moment to read about our payment and billing terms so that there is no misunderstanding later concerning our fees and billing practices.

Fees for services are due at time of service. We will submit to your insurance provider, however, your eligibility and coverage information provided to us may change during claims processing. At Boever Family Eyecare we do require 50% down on all materials ordered and the remaining balance is due at the time of pick up. For those without Vision coverage we do offer "Care Credit" and a "Time of Service" savings. An Optician can answer any questions you may have regarding this.

It is the patient's responsibility to let Boever Family Eyecare know the name of their Medical and Vision Insurance. By signing below you authorize Boever Family Eyecare to submit claims on your behalf and accept payments directly from your insurance company. Any non-covered services or materials including co-pays are your responsibility. Statements are mailed monthly and prompt payment is appreciated.

Initialing this document signifies that you understand our Payment & Billing Terms.
(Initial Here):_____

SECTION B: HIPAA

I have been made aware of Boever Family Eyecare's HIPAA Notice of Privacy Practices.
(Initial Here):_____

SECTION C: Pupil Dilation Information

Pupil dilation enables the doctor to have a better view of the inside of your eyes to evaluate the retina, nerves, and blood vessels of each eye. **The drops will affect your vision for 3-5 hours.** We will provide you with disposable sunglasses to protect your eyes after dilation. There is no extra fee for dilation if it is done at the time of your full eye examination.

Please mark your choice for dilation at this visit:
____IF NEEDED, Yes, I give consent for dilation ____ No, I do not give consent for dilation today

SECTION D: AUTHORIZATION/NOTIFICATION

By signing below I understand and agree that this office and any service providers may contact me by sending text messages, placing phone calls, or sending emails to any phone number or email address I provided to this office. I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication.

By signing below I acknowledge I have read and understand this document in its entirety.

Patient Name:_____ Patient/Guardian Signature:_____

Date:_____