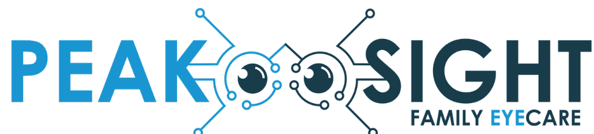

Darion M. Horner, O.D.
Keith E. Whaley, O.D.
PHONE (865) 428-0959
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PeakSight Family Eyecare, PLLC
2541 Sand Pike Boulevard
Pigeon Forge, TN 37863

Office Policies

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. By signing below you attest that you have received, and understand this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act).

INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to PeakSight Family Eyecare, PLLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information about me to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

FINANCIAL ASSIGNMENT AND AGREEMENT

I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductibles, copays, or other charges not paid by my insurance company. I will be expected to pay for those services and/or materials in full if denied by insurance.Should my account become delinquent and require the services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for collection.

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. **Vision care plans** (such as VSP and EyeMed)
2. **Medical Insurance** (such as BCBS and Medicare)

- Vision plans ONLY cover routine vision exams, and may cover some materials (such as glasses or contact lenses.) Vision plans only cover the basic preventative screenings for eye disease. They DO NOT cover and will not pay for diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problems or systemic health problems that have the potential for ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history, i.e., Diabetes.
- If you have both types of insurance, it may be necessary for us to bill some services to one plan and other services to another. We will use coordination of benefits to do this properly and minimize your out of pocket expense. (VSP provides coordination of benefits, EyeMed does not)
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

I have read the above policies and agree as indicated by my signature.

Patient Name (or guardian) ____

Signature ____ Date ______________

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CANCELATION/NO SHOW POLICY

I acknowledge that PeakSight Family Eyecare, PLLC has the right to refuse to rebook me if multiple no shows occur. They may also only offer me same day appointments, require my charges upfront and/or charge a no show/rebooking fee prior to being seen in their office again.

CONSENT FOR TREATMENT

I authorize PeakSight Family Eyecare, PLLC to administer diagnostic and medical procedures as may be necessary for proper health care.

DILATION

Your eyes may be dilated as part of your eye examination. The dilation drops may cause light sensitivity and blurred vision. The drops allow the doctor to obtain a comprehensive view of your eye health including the retina (nerve tissue that creates vision.)

CONTACT LENS PATIENTS

In addition to the comprehensive eye exam, there will be a contact lens evaluation fee. I understand that I am responsible for all contact lens services and contact lenses when not covered by my plan. Our evaluation fees include follow ups to adjust the fit and vision of the contact lenses for a period of 60 days:

Standard Soft Lens Evaluation/Fit	(Spherical)	**$70**
Superior Soft Lens Evaluation/Fit	(Toric, Multifocal/Monovision, Extended wear)	**$105**
Medical/Rigid Lens Evaluation/Fit	(CRT, Post Surgical, Keratoconus)	**$225+**

Once an acceptable lens is determined a contact lens prescription will be finalized by your doctor and a copy provided to you. Contact lens prescriptions are valid for 1 year unless there is a specific medical concern.

REFRACTION - The fee for this procedure is $40.

Refractions are not covered by medicare or other medical insurance providers but still may be an important part of your eye exam. A refraction is necessary to update glasses and contact lens prescriptions and can be helpful in monitoring changes to eye health. Vision plans often cover a refraction during your preventative exam but may have restrictions.

OPTOMAP AND RETINAL IMAGES - The fee for this procedure is $35.

Retinal images are taken at every comprehensive exam in order to track changes and may not be covered by insurance. Patients with retina pathology will need more detailed images as appropriate.

AFFIRMATIVE CONSENT TO PROVIDE INFORMATION ELECTRONICALLY

I consent to PeakSight Family Eyecare, PLLC using electronic means (text messaging, email, fax, web portal) to transfer my information to myself, pharmacies, physicians, insurance companies, etc.

I have read the above policies and agree as indicated by my signature.

Patient Name (or guardian) ______________________________

Signature ______________________________ Date ______________