APERTURE VISION

Thi Nguyen O.D. & Huong Nguyen O.D.
10107 Research Blvd. Austin, TX 78759 (512) 339-5140

Office Policy

1. In the event my insurance provider determines that I am not eligible for visual insurance coverage or eligible for a reduced level of coverage, by signing this statement, I hereby agree to be financially responsible for any and all charges incurred by me and not paid by my insurance provider.
2. I understand all fees of services rendered are due at the time of service and are non-refundable.
3. **I understand there may be a re-check or re-fit fee if I request a change to my vision prescription after 90 days from the initial exam / date of service.**

Please note that we are separate from the optical next door and do not sell any glass or contact lens materials

Medical Release Authorization and Insurance Assignment

All vision insurances must be pre-approved prior to your examination. If we are unable to verify coverage, all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits or are eligible for less than full coverage, you agree to be financially responsible for any unpaid balance. **If you discover that you have insurance after services are rendered, it is your responsibility to file your own claim for reimbursement. The doctor's office will not back the file claims, post authorize, or refund fees. You also acknowledge that certain examinations and exam findings may not fall into the realm of a routine eye exam, and may deem to be medically necessary to file under your medical health insurance or will need to be referred to another office.** You also authorize the release of any medical or other information to process insurance claims.

Acknowledgement of of Notice of Privacy Practice

In the process of providing services requested, we will collect, use, and share certain information provided by the patient. You may request a copy of this form at any time.

TREATMENT: We are permitted to use and disclose your medical information to those involved in your treatment, including but not limited to hospital staff, primary care physicians, and specialists.

PAYMENT: We are permitted to use and disclose your medical information to bill and collect payment for services provided to you.

DISCLOSURES WITHOUT PATIENT AUTHORIZATION: There are situations in which we are required by law to disclose or use your medical information without written authorization or opportunity to object. These include but are not limited to: public health activities, abuse/neglect, health oversight, legal proceedings, law enforcement, worker's compensation, or as otherwise required by law.

RESTRICTIONS: You may request that we restrict or omit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to restrictions, but if we do agree, we will comply with your request except under emergency situations.

I have reviewed Aperture Vision's Notice of Privacy Practices which explains how my medical information will be used and disclosed.

Signature of Patient/Guardian _____ Date: _____