HIPAA Consent for the Release of Information and Financial Responsibilities:

I consent to the use and disclosure by Vaughn's Family Vision LLC/ DBA Advanced Eye Care and Dr. Alexia C. Vaughn (AEC) any information, e.g. health information concerning my examinations and products, to any part and/or agent, including, but not limited to my employer, medical or optical provider, health plan or plan sponsor ("plan"), as needed for the treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the AEC (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the AEC).

If I desire to seek third party reimbursement for the services received, I authorize AEC to submit an insurance claim for payment to any third party as identified.

I understand that I am responsible for all charges incurred, including any portion not paid by the third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the AEC in writing, except for any disclosure already taken in reliance of my consent to release information; however, AEC is not required to agree to my request. A full copy of our HIPAA is available upon request.

Acknowledgement of Receipt of HIPAA Policy:

AEC is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and healthcare operations when necessary.

Insurance Policy and Collection Fees to Account Balances:

As a part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical and vision services. To avoid any misunderstandings please read the following statements carefully:

- The Legal obligations of your insurance provider are between you and your provider, not between this practice and your provider.
- When your insurance provider(s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination coverage's. Unpaid balances are the sole responsibility of the patient.
- To keep the cost of the records and collections down, any patient portion amounts on your order will be due at the time of service.
- I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help in obtaining payment from my insurance companies.
- I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.
- Returned checks will incur a fee of $35.
- **I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collections (33.3%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.**
- **Express Prior Consent to Contact Consumer by Cell Phone: You agree, in order for us to service your account or to collect monies you may owe, Vaughn's Family Vision LLC/ DBA Advanced Eye Care and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.**
- I/We have read this disclosure and agree that Vaughn's Family Vision LLC / DBA Advanced Eye Care, its employees and/or agents may contact me/us as described above.

Signature _____ Date _____

Eyeglass, Contact Lenses, and Other Materials:

All eyeglasses, contact lenses, and any materials must be paid in full before ordering.

Frame Warranty:

All prescription frames are warranted against manufacture's defects for twelve months from the date of purchase. The warranty for frames covers manufacturing defects but not damages induced by the wearer or due to excessive conditions such as heat, moisture, breakage, etc. Patients Own Frame (POF) does not have a warranty. AEC and the Lab used to make the POF glasses will not be responsible for any breakage or damage of the frame during adjusting, repairing, cleaning, or glasses processing. **The warranty replacement fee is $25**.

Prescription Lens Return(s):

If the prescription lenses you ordered are not correct due to lab error or our doctor's error, please return within 30 days of the receipt of the product and they will be remade at no charge. Please note that since prescription lenses are customized and made especially for you, they are **NOT** refundable.

Prescription lenses come with a scratch resistant coating which is not scratch proof. There is no warranty on lenses unless you have Crizal brand antiglare which comes with a warranty for scratches for 6 months of date of purchase.

Contact Lens Return(s):

If you wish to exchange or return contact lens, please return them within 30 days of your receipt of the product. ONLY unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

Advanced Eye Care
A Healthy Focus

Contact Lens Fits:
Contact lens fitting and evaluation fees are not part of a comprehensive eye exam. These services are separate charges. The charges are as follows: spherical fit $50, toric fit $70, multifocal $85, RGP $95. We cannot guarantee that you will be able to successfully wear contact lenses, and if you are not, the fee for the service is not refundable. Contact lens fits must be completed within 30 days. If not completed within the allotted time period a refit fee of $45 will be charged. If a contact lens fit is the only service desired, you must have had a comprehensive eye exam within the past 8 months.

Cancelling an Eyeglasses order:
We will allow you to the end of the business day at 5:00 PM central time on the same day order was placed to cancel. Please bear in mind that once an order is placed it is electronically sent to the lab and they start manufacturing your lenses. If the lab has already started, you will not be able to cancel your order. Acceptable methods of cancellation only include speaking directly to an AEC employee.

Clinical Services:
No refund will be made on clinical procedures, services, or prescription lenses. Eyeglasses/contact must be paid in full before it can be dispensed.

Work/School Excuses:
Excuses are only given for patients who have an appointment to see the doctor not for dilation or to pick up materials. Excuses for missed days will only be given if you have a condition that is contagious.

Cancellation Policy:
Appointments must be cancelled within 24 hours or a $30 charge will be assessed. The charge must be paid before other services are rendered.

Digital Retina Photography:
We now offer digital retina photography as an add-on to your comprehensive eye exam. This technology allows us to take photos of the back of the eye and have documentation so that we can more closely monitor any changes you may have. You should have photography if you have a personal or family history of glaucoma, macular degeneration, other eye diseases, high blood pressure, diabetes, or other diseases that can also affect the eyes. Your insurance company does not cover this advanced testing as part of a comprehensive eye exam. **The fee is $15.** If you would like this test please check yes or no below:

_____Yes, I want digital photography _____No, I do not want digital photography

I acknowledge that I have received this notice regarding HIPAA and AEC office policies

Name of Patient (print) _____

_____ _____

Signature of patient or authorized representative **Date**