305 W FM 1382
Suite #524B
Cedar Hill, TX 75104
infocusvisionch@gmail.com
PHONE#: (833) FOCUS-TX
FAX#: (972)-212-6145

InFocusVision
we focus on you

CONSENTS

HIPAA/PRIVACY ACKNOWLEDGE & RECEIPT OF NOTICE OF PRIVACY PRACTICES:

As required by law, InFocus Vision makes every effort to maintain confidentiality and to provide patients with notice of legal duties and privacy practices with respect to protected health information (PHI). By initialing, I acknowledge that copies of InFocus Vision's Notice of Privacy Practices have been made available to me for my records.

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INITIAL HERE

If you are having trouble adapting to your new glasses, **you have up to 30 days** from your original exam date to return for one prescription re-check. **After this 30 day grace period, re-check appointments will incur a $35 office visit fee.**

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INITIAL HERE

FEE FOR MISSED APPOINTMENTS:

Due to the high demand of appointments, our staff at InFocus Vision makes every effort to accommodate our patients' medical needs. Please be courteous, and call promptly if you are unable to keep your appointment, as there are always patients waiting and wanting to be seen as soon as possible.
If you are unable to keep your scheduled appointment, our office requires a 48 hour notice.
A charge of $50 will be incurred for every appointment missed without proper notification as outlined above.

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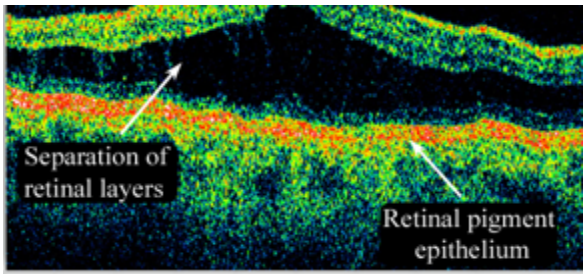
INITIAL HERE

OCT | Tomography Screening: non-invasive test that provides 3-D color-coded, cross sectional images of the retina to enable early detection and treatment of ocular disease that may develop without any noticeable symptoms. **(NOT RETINAL IMAGING & NO DILATION)**

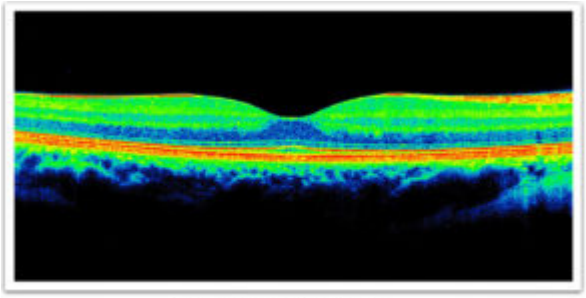
Cost for the OCT Screener is $40.

OCT scans are used for diagnosis, management or treatment of a variety of ocular conditions: Macular Edema, Age-Related Macular Degeneration, Diabetic Retinopathy, Macular Hole, Vitreomacular Traction, Glaucoma, Drusen, Retinal Occlusions or Bleeding, Retinal Detachment, and More.

□ **Yes, I would like to do the OCT eye exam today.** □ **No, Thank you, not today.**



Abnormal Scan



OCT Normal Macula

ANNUAL APPOINTMENT REMINDERS:

As part of our efforts to maximize patient care, at **InFocus Vision**, patients may opt into our "pre-appointment" system to avoid running out of contacts, missing out on insurance benefits, etc.

□ **Yes! Please remind me, and schedule a tentative appointment for my annual exam.**
□ **No, thank you. I would like to opt out of the pre-appointment system at this time.**

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AUTHORIZATION TO RELEASE INFORMATION (OPTIONAL – EX. PARENT, SIBLING, SPOUSE)

On behalf of myself as a patient or as the patient's parent/legal guardian, I authorize INFOCUS VISION, and staff to discuss health information from medical records, to person specified below:

_____ _____

PLEASE PRINT
NAME OF AUTHORIZED INDIVIDUAL

RELATIONSHIP
TO PATIENT

COMMUNICATION PREFERENCES: Please indicate your preferred method(s) of contact below, as applicable.

□TEXT&CELL/HOME
(CIRCLE ONE) _____

□ EMAIL _____

□CURRENT
ADDRESS _____

Email Authorization:

I authorize InFocus Vision to send my protected health information, i.e., glasses/contact lens prescription, etc. via unencrypted email. I understand there may be some level of risk that the information in the email could be read by a third party. You have the right to revoke this authorization at any time, by writing a letter stating you no longer wish to authorize InFocus Vision to send health information via email with your legal signature.

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INITIAL HERE

**If individuals are notified of the risks and still prefer unencrypted email, the individual has the right to receive protected health information in that way, and covered entities are not responsible for unauthorized access of protected health information while in transmission to the individual based on the individual's request. Further, covered entities are not responsible for safeguarding information once delivered to the individual.
(US Department of Health and Human Services, 2013)

CONSENT FOR TREATMENT:

By signing this form, I consent to and authorize my provider(s) at InFocus Vision to treat me or my dependent. I understand this could include annual examinations, medication prescriptions and/or administration, education, or other diagnostic tests. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect as long as I attend any of the InFocus Vision Clinics. **By signing below, I am attesting, I have legal authority to make medical decisions for the child. If you cannot attest to this, InFocus cannot provide care to the minor.**

PATIENT NAME: _____ TODAY'S DATE: _____

(PRINT PATIENTS NAME) MM / DD / YY

SIGNATURE: _____

PATIENT SIGNATURE OR PARENT / GUARDIAN