

Assignment of Release of Insurance

By initialing I certify that I, and/or my dependent(s) have coverage with the insurance company indicated on the patient profile form and assign directly to Dr. Jessica N. Lemons all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. Claims will be filed by HCFA or electronically.

Notice of Privacy Practices Acknowledgement

By initialing I acknowledge the full notice of privacy practices of Gallatin Valley Vision, LLC is available by request from our check in desk. I have read (or had the opportunity to read if I so chose) and understand the notice.

Is there anyone, besides yourself, that we may discuss your medical information with? If yes, please list:

Dilation Consent

Our doctor uses eye drops to dilate your pupils as part of a comprehensive eye evaluation. There is no additional fee for this service. Pupil dilation allows the doctor to better view key structures of the eye, to determine if you have any disease that may affect your vision. These drops typically cause decreased reading vision and light sensitivity for about 3-4 hours. Usually, distance vision is minimally affected.

Yes, I consent to having my eyes dilated.

No, I decline to be dilated. I understand that certain medical conditions that may affect my vision may not be detected by my refusal and I accept all risks and responsibility.

Digital Retinal Imaging Consent

Retinal imaging allows instant viewing of the back of the eye without pupil dilation. While taking the retinal photo does not replace the need to have your eyes dilated, it is strongly recommended that you have photos taken if you plan on declining dilation at today's visit. Some insurance plans offer this service at a lesser co-pay than the normal fee we typically charge. You will be charged for the lesser amount if covered by your insurance.

Yes, please perform the Digital Retinal Imaging as recommended. ***The fee for this service without insurance is \$40***

No, I do not wish to have the optional imaging performed.

Patient Name: _____ Authorized Signature: _____

Date: _____ Relationship to Patient: _____