

TALLMADGE FAMILY EYE CARE, LLC

PUPIL DILATION CONSENT/REFUSAL

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes. This allows a better examination of the eyes' internal structures. Thorough examination of these structures is necessary to rule out various eye diseases or pathology.

The pupils are simply an entryway or opening to the inside of the eyes. Looking through an *undilated* pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eyes.

**A dilated retinal examination is recommended routinely at the time of your comprehensive eye examination, or at other intervals as advised by your eye doctor.**

Dilation of the pupil causes temporary sensitivity to light and blurring of near vision in most individuals. Blurring of the distance vision may occur as well in individuals with uncorrected farsightedness. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. Dark glasses will be provided after your examination to aid with the light sensitivity.

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**CONSENT:** I consent to have my pupils dilated at this time, if in accordance with the recommendations of my doctor. I understand that this service is included in the price of the examination, and **NO EXTRA CHARGE** will be assessed.

**REFUSAL:** I refuse to have my pupils dilated at this time. **I understand that my ocular health cannot be thoroughly evaluated without pupil dilation.**

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Patient Signature

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Date

## TALLMADGE FAMILY EYE CARE, LLC FINANCIAL POLICY

### INSURANCE, REFERRALS, NON-COVERED SERVICES & SELF PAY

We will attempt to verify your plan eligibility for services and/or materials before your appointment. Verification of benefits is provided as a courtesy only and is not a guarantee of coverage or payment. It is your responsibility to know your insurance benefits and requirements, including if any benefits require a referral or pre-authorization. If your plan requires a referral or pre-authorization, you must provide and coordinate referrals to us from your primary care physician or confirm that we have obtained this requirement prior to your appointment. If any referrals or pre-authorizations are incomplete, the cost of these services may become your responsibility.

Any and all applicable copays are due at the time of service. Non-Covered services may also be due at the time of service.

If we do not participate in your insurance plan, payment in full is expected from you at the time of service. We will supply you with an invoice that you can submit to your insurance for reimbursement.

If you do not have health or vision insurance, payment must be made in full at the time of service. A driver's license or other identification will be required for all self-pay accounts. Until your insurance plan eligibility is verified, your account will remain as self-pay and you will be required to make payment at the time of service. If you are a self-pay patient and pay in full at the time of service, you will receive a 20% discount on the services at your office visit (excludes optical and contact lens purchases).

### GLASSES, CONTACT LENSES, & OTHER MATERIALS

50% of the cost of any glasses frames, glasses lenses, contact lenses or other optical materials must be paid before any orders will be placed. If any insurances are being used toward the purchase of glasses frames, glasses lenses, contact lenses, or other materials, 100% of the remaining patient obligation must be paid before any materials will be ordered. Glasses frames, glasses lenses, contact lenses or other optical materials must be paid in full before any materials will be dispensed to you or other responsible party.

Reasonable attempts will be made to contact you for pick-up when materials have been received by Tallmadge Family Eye Care; however, you are ultimately responsible for arranging pick-up of any ordered or purchased items. TFEC cannot be held responsible for disconnected phone numbers, clerical errors, or other impediments to contacting you or responsible party in a reasonable manner. Tallmadge Family Eye Care may, at its sole discretion, attempt to mail to you any items which have been paid for in full. However, TFEC is under no obligation to do so, and may charge you for any associated shipping and handling fees incurred in so doing.

Any materials that have been ordered, whether paid for in part or in full, will be held for no more than 90 days from the original order date. If materials are not paid in full and claimed within 90 days, any glasses frames, contact lenses, or other materials may be: returned to the manufacturer for any eligible refunds, returned to TFEC inventory, or disposed of. Any unclaimed materials will be returned or disposed of 90 days after the original order date, and you will still be responsible for the payment in full.

### FINANCIAL RESPONSIBILITY

Your balance is due in full upon receipt of your monthly statement. This includes coinsurance, deductible, services not covered by your insurance policy and unpaid services billed to your insurance company following repeated attempts by our Billing Coordinator to resolve the disputed claim. You are responsible for working with your health insurance company should they request additional information from you for claims to be paid. Failure to make your payment in full, or as arranged, may impact your healthcare services relationship with Tallmadge Family Eye Care, LLC and your physician.

We accept gladly accept cash, checks, Visa, MasterCard, Discover and CareCredit. For each returned, NSF check, our fee is \$45.00. If we receive an NSF check, we will not accept another personal check from you until the NSF fees are paid and a payment for the returned check has been made. If we receive two (2) returned checks on your account, we will no longer accept personal checks from you.

Patient/guarantor credits will be refunded in accordance with the policies established with our Billing Office.

**I have read and understand the Tallmadge Family Eye Care Financial Policy. If I have medical or routine vision benefits, I agree to assign insurance benefits to TFEC whenever necessary and authorize TFEC to release any information required for payment to be made.**

**Signature of Patient/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TALLMADGE FAMILY EYE CARE, LLC**  
**PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FORM**

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal healthcare information is protected. The privacy rule was created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and sharing with others health information regarding treatment, payment, and healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide only the minimum necessary information to those we feel need your information in order to provide the care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with others (for example a laboratory) and may have to disclose personal health information for the purposes of treatment, payment, or healthcare operations. These partners in your healthcare are also most often not required to obtain patient consent.

You may refuse consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

If you choose to give consent in this document, at some future time you may request to refuse to release all or part of your PHI. You may not revoke your decisions that have already been taken which relied on this or a previously signed consent.

Our **Notice of Privacy Practices** describes in detail how medical information about you may be used or shared and how you can get access to the information. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. If you have any questions or objections to this form, please ask to speak with the Office Manager or our HIPAA Privacy Officer.

Thank You!

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**Patient/Legal Guardian Name (Printed)**

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**Patient/Legal Guardian Signature**

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**Date**