## Release Form

Thank you for choosing us as your healthcare provider among your many choices for eye care professionals. Today you will receive a thorough eye examination and accurate prescription as a part of your evaluation. A dilation will also be performed or scheduled to rule out such maladies as glaucoma, retinal detachment, cataracts, eye tumors and other sight or life threatening conditions. We always prefer to have our patients driven after their dilation, as the eye drops have an affect towards blurred vision and light sensitivity, especially on sunny days.

As a part of the latest technological advances in eye care retinal photography will also be performed. Dr. Staffier will review photos with you as needed and they will then serve as a baseline to compare against changes in the future. All patients over 18 years of age will have a visual field screening performed. These services will be submitted to your insurance carrier. If this presents a problem please ask for a waiver form. We hope you are beyond satisfied with your exam and will again look to us for eye care needs years to come. Thank you from the staff at Dr. Eric A. Staffier, O.D. P.C.

**There exists a separate, nonrefundable, and noninsurance submittal fee for all contact lens fitting and evaluations.**

There will be no refunds for rendered medical and professional services related to your eye exams and contact lens fitting and evaluations.

## Assignment and Release

I authorize payment of benefits directly to Dr. Eric A. Staffier, O.D. P.C. for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I authorize the use or disclosure of my information to Lenscrafters. Description of information that may be used/disclosed: My name, address, telephone number, email address, and next appointment date(s) and time(s).

I understand that some services may require prior approval from my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for services.

I understand that my primary insurance carrier is billed first. All secondary medical insurance carriers and vision plans will be billed upon direction/ or denial of primary insurance. I understand my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and Fees not paid by my insurance carrier will be my responsibility. I also understand that in the event that I receive a statement for the balances owed. I will be charged a $15.00 late fee after 45 days and a $50.00 collections fee after 90 days of non-payment.

**I acknowledge that a copy of the "Notice of Privacy, HIPPA" policy will be provided upon request at Dr. Eric A. Staffier, O.D. P.C.**

Signature_____ Date: _____

If under 18, Signature of responsible party above. Please print name below

Printed Name: _____