HINSDALE EYE CENTER, LLC
EXCELLENCE IN EYE CARE

REFRACTION INFORMATION: A "refraction" is the process of determining the optimal eyeglass and/or contact lens prescription for your eyes. This is not only to allow us to prescribe eyeglasses and/or contact lenses, but more importantly to determine your best corrected vision. The refraction helps us to distinguish whether vision problems are caused by glasses, contact lenses or from eye disease. A refraction may or may not be performed at the time of your visit, depending upon your doctor's judgment of its necessity. This service is not covered by Medicare or by private medical insurance. If a refraction is performed, there will be a fee of $50.00 due at the time of service. **Initial_____**

DILATION INFORMATION: I acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after examination, you may choose to make arrangements not to drive yourself. **Initial_____**

PRIVACY PRACTICES: I acknowledge that a copy of HEC's Notice of Privacy Practices has been offered for my review and a copy is available at my request and on the practice website. **Initial_____**

I authorize HEC to leave a message on my voice mail for test results. **Initial_____**

Name of person(s) that you authorize HEC to disclose your personal protected health information to:

Name (s)	Relationship	Contact Number (s)

FINANCIAL ASSIGNMENTS AND AGREEMENTS

I acknowledge that I am responsible for knowing my own insurance coverage and presenting my correct, valid insurance card. I acknowledge that my insurance coverage is a contract between me and my insurance company, and the goal of the eye center is to assist me to the best of their ability using the information provided to them. It is my responsibility to provide current, accurate and complete information before receiving services. **If the correct insurance information is not furnished at the time of service, Hinsdale Eye Center has the right to refuse additional claim submissions.**

I request that payment of insurance benefits be made payable directly to Hinsdale Eye Center, Ltd. for any services furnished to me by that provider. I authorize Hinsdale Eye Center, Ltd. to release to my insurance carrier any information needed to determine those benefits or the benefits payable to the related services. This authorization is in effect until I choose to revoke it.

I understand that I am financially responsible for all charges not covered by insurance including co-pays, deductibles and no show/cancellation fees. **If I default and do not pay, Hinsdale Eye Center, Ltd. is entitled to the right of recovery of all collection expenses up to 35%, including all collection agency costs, court costs and reasonable attorney's fees incurred for the purpose of securing payment.**

Signature:_____ **Date:_____**
(Patient, legal guardian or authorized party)

Printed Name of Patient:_____