OFFICE POLICIES

i Vision Optometry is proud to introduce the Optomap Retinal Exam. In our continued effort to bring the most advanced technology available to our patients, we offer the Optomap exam to all our patient. Many eye problems can develop without warning and progress with no symptoms. The Optomap exam provides: A scan to confirm a healthy eye or detect the presence of disease, an overview of the retina, giving the doctor a more detailed view than cannot be achieved by other means, a permanent record for your medical file, enabling the doctor to make important comparisons if potential problems show themselves at a future examination. Additional fee may be required, please ask any of our staff for more information.

PRESCRIPTION POLICIES:

We do not take any responsibility in the accuracy or quality of materials made outside this office. If you choose to have your eyeglasses made outside of this office, we recommend you reach an agreement with your eyeglasses dispenser before you place your order. They should agree not to charge you in the event your eye prescription needs to be redone. If you choose to make your eyeglasses in this office, we provide you with a 1 time prescription lens change in your eyeglass prescription within 3months of your original diagnosis.

FINANCIAL POLICIES:

1. For patients with insurance, it is expected that your insurance will not pay for all services or materials that are received in this office. You will be financially responsible for any services or materials that are not covered by or paid for by your insurance company.
2. For patients with insurance in which this office is not a network provider, the patient is expected to pay all expenses at the time services and/or materials are completed. It will be the responsibility of the patient to bill their insurance company directly for reimbursement.
3. All insurance Co-Payments must be paid upon the completion of services.
4. All balances must be paid prior to the release of materials.
5. We do require a 50% deposit before any materials will be ordered. Deposits for materials not picked up within 90days will be forfeited. There will not be any refunds. An office credit may be applied to your account within 6months of original order date, providing materials can be returned to manufacturer for credit.

In acknowledgment of the above policies, please sign and date in the areas below.

I have read and agree to the above policies:

Responsible Party Name (Please print): _____

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

INSURANCE ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependant) have insurance coverage with _____
(Insurance company name)
and assign directly to Ikuko Sugimoto O.D. and i Vision Optometry 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 the insurance company. I hereby authorize Ikuko Sugimoto O.D. and i Vision Optometry to release any information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

IF YOU WOULD LIKE A PRESCRIPTION FOR CONTACT LENSES,

PLEASE CONTINUE AND COMPLETE PAGE 2.

CONTACT LENS SECTION

CONTACT LENS QUESTIONNAIRE:

1. Do you currently wear contact lenses? □Yes □No If No, please skip this section.
2. What type of contact lenses are your currently wearing? □Rigid □Soft
3. If you are wearing soft contact lenses what is your current modality of wear?
   □Daily disposable □2week disposable □Monthly disposable □Quarterly replacement □Other
4. How old is your current pair of contact lenses? _____
5. Are you satisfied with the vision and comfort of your current pair of contact lenses? □Yes □No
6. Would you like to: □Continue with what you have □Change to: _____
7. Do you prefer clear or colored contact lenses? □Clear □Colored □Both
8. Please check all that apply to your contact lenses:
   □Feel less comfortable in the afternoon □Feel painful after insertion
   □Are not as clear as I would like □Feel irritated and/or eyes become red after wearing for a few hours
9. Please describe any concerns you have with your contact lenses:

   _____

CONTACT LENS FITTING AND EVALUATION FEES:

Contact lens fitting fees start at $95.00 and may increase depending on each patient's prescription and needs.
Included in this fee are:
Slit Lamp Examination, Corneal Topography and 2 follow-up visits within the first 30days (If necessary)
If your fitting requires any additional contact lens fitting visits, the cost will be an additional $39.00 per visit.

SHIPPING:

If you are currently wearing disposable lenses, you have the option of your final set of lenses shipped to your home or office, for an **ADDITIONAL SHIPPING CHARGE**. If you purchase a year supply of contact lenses and have your account paid in full, there will be **NO CHARGE** for shipping. Since contact lenses will probably be sent direct from our distributors, the estimated time of shipping will vary.

CONTACT LENS PRESCRIPTION POLICY:

1. The contact lens prescription will be released only when you and the doctor are satisfied with the comfort, fit and vision of your contact lenses.
2. You will be responsible for keeping your scheduled contact lens follow-up visits.
3. We do not take any responsibility for contact lenses purchased outside this office.

   a) If the prescription changes or the physical fit of the contact lenses changes, you will be responsible for the cost of any new contact lenses. It will be your responsibility to check with the contact lens seller, concerning their return and exchange policies.

   b) You will not be eligible for free use of loaner contact lenses.

   c) From this date forward, you will hold free and harmless Dr. Sugimoto and i Vision Optometry from any compromise in your vision and eye health that are caused by defective contact lens materials purchased outside this office.

In acknowledgement of the above policies, please sign and date in the areas below.

I have read and agree to the above policies and conditions:

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____