Name:_____ Date of Birth:_____/_____/_____

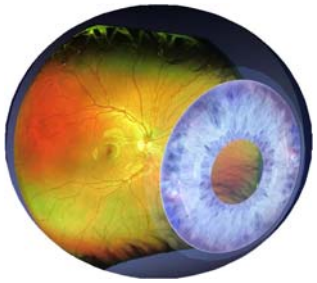
******If your address and insurance have changed, please update with the staff******

FINANCIAL RESPONSIBILITY AGREEMENT REMINDER

All Charges are non-refundable. Payment is due at time of service. Eye care for medical conditions not covered under routine wellness exams. Medical eye visits and contact lens evaluations carry additional charges.
Initial Here_____- I am financially responsible for all charges incurred during eye exams or office visits.

Optomap Retinal Screening

At Clearly Eye Care, we believe that yearly retinal evaluations are critical in early diagnosis and monitoring of your eye health. Therefore, we have acquired the Optomap Retinal Scanner to capture wide angle images of the retina and detect early signs of eye disease without having to dilate the eyes. It is fast, easy and comfortable. This advanced technology is doctor recommended on every patient as part of their yearly exam and carries a $39 charge.



I would like to have the Optomap performed today: NO

Dilation

If you choose not to have retinal imaging performed, or if certain medical conditions are present, you may require dilation. The drops cause light sensitivity and blurry vision for up to 4-6 hours.

I would like to be dilated today: NO

NOTICE OF PRIVACY PRACTICES & 30 DAY INCLUSION PERIOD

1. I have read and understand Clearly Eyecare's Notice of Privacy Practices Form.
2. I also understand that I have 30 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 30-day period may be subject to an additional examination fee due to possible changes in vision.

_____ _____
Patient Signature (or Guardian's Signature) Date

INSURANCE & PAYMENT POLICY

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will be required to pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We are not responsible if you are not eligible for benefits. We will be happy to assist you with your claims.

_____ _____
Patient Signature (or Guardian's Signature) Date

COVID-19 PANDEMIC ESSENTIAL EYE EXAM AND TREATMENT CONSENT FORM

Patient Name: _____ DOB: _____ Date: _____

Please read and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, and loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state or country in the last 30 days.

I understand that Clearly Eyecare, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Clearly Eyecare or any of its doctors and staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge DLV and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____	_____	_____
PRINT LEGAL NAME	SIGNATURE	DATE