COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: _____
Today's Date:_____

Please read the following statements 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 have, nor have I had in the last two weeks, a fever, cough, sore throat, loss of smell/taste, chills, aches 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 (thirty) days.
_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state of Colorado in the last 30 days.

I have read the above and have answered the health questions above honestly and to the best of my knowledge. I understand that Spring Creek Eye Care, PLLC its doctors, assistants, 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 Spring Creek Eye Care, PLLC or any of its doctors, assistants, 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 an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Spring Creek Eye Care, PLLC and its doctors, assistants and staff for injury, loss or damage elated to COVID-19 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

Digital Retinal Photography

The Optomap provides a quick and comfortable image of the retina, often without the need for dilation. Retinal disease can occur at any age regardless of overall eye health and usually has no noticeable symptoms. Without a retinal exam, it is often not possible to detect these conditions. RETINAL PHOTOS ARE STRONGLY RECOMMENDED YEARLY TO ALL OF OUR PATIENTS. In certain cases the Doctor will still recommend dilation along with retinal photography. **The additional fee for this test is $39.00**

The benefits:

- An enhanced, high resolution digital image of the blood vessels and the inner lining of the eye.
- The image becomes part of your medical record allowing us to monitor for future changes.
- Enables the early detection of many health conditions including high blood pressure, diabetes, macular degeneration, glaucoma, retinal holes and retinal detachments.

_____ Yes, I consent to this procedure.

HIPAA CONSENT FORM

Spring Creek Eye Care, PLLC provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Spring Creek Eye Care, PLLC and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Spring Creek Eye Care, PLLC or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment & referral
- To obtain payment & file insurance
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care
- For research and education
- To prevent serious threats to health safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Spring Creek Eye Care, PLLC may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Spring Creek Eye Care, PLLC. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to or upon me, which may be advised or necessary.

The information and Notice of Privacy Practices is made available on request.

Signature: _____ Social Security:_____
Patient Name: _____ Date: _____
Relationship (if other than patient): _____
Witness (practice representative): _____

INSURANCE CONSENT AND RELEASE

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the following insurance companies and assign directly to Spring Creek Eye Care, PLLC all insurance benefits, if any, otherwise payable to me for services and/or materials rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the optometrists and their respective assistants to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance #1 _____
Insurance #2 _____
Insurance #3 _____

Member Name: _____ Date: _____
Member Signature: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Spring Creek Eye Care, PLLC for services furnished me by Spring Creek Eye Care, PLLC. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.** In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

Beneficiary Name: _____ Date: _____
Beneficiary Signature: _____