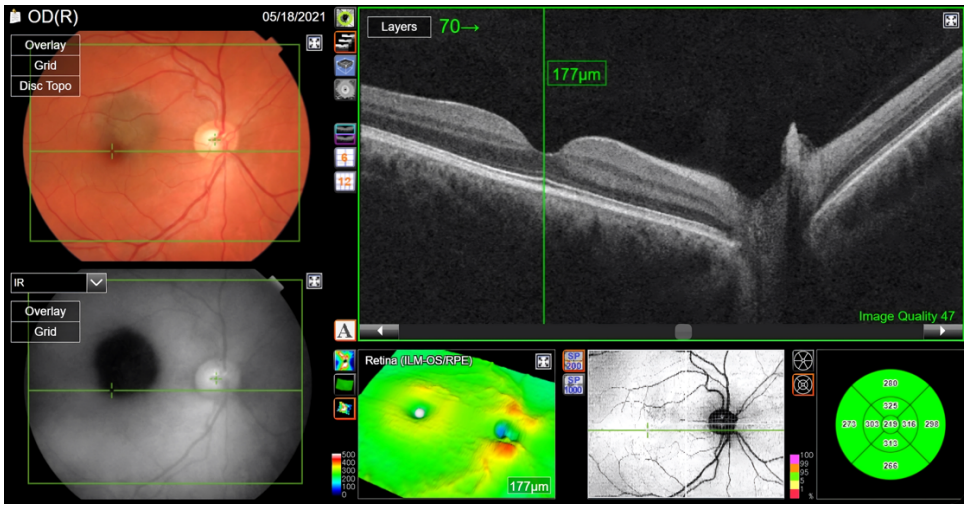
Comprehensive
Ocular Imaging

At Premier Eye Associates, your eye health is our top priority. To ensure the highest level of care, our doctors incorporate **Comprehensive Ocular Imaging** as part of our comprehensive eye examinations. Our state-of-the-art imaging technology provides detailed retinal photography or advanced MRI-like scans of the retina and optic nerve, allowing our doctors to evaluate and monitor your eye health with exceptional precision.

This imaging enables early detection of conditions such as macular degeneration, glaucoma, diabetes, high blood pressure, melanoma, retinal detachments, and many other sight-threatening disorders, often before symptoms occur.

- Safe for all ages.
- Painless and fast.
- Does not require dilating drops.
- Allows you to view the inside of your eyes alongside your doctor.
- Provides detailed images that can be compared each year to detect subtle abnormalities.



I have read and understand the above and agree to the Comprehensive Ocular Imaging copay of $39.

_____ ____/____/____

Patient / Guardian Signature Date

PREMIER EYE

PATIENT INFORMATION	
First Name:	Last Name:
Preferred Name:	Phone Number:
Email:	Date of Birth:
Social Sec #:	Occupation:
Marital Status:	Sex:
Address:	City:
State:	Zip:

PARENT / GUARDIAN INFORMATION (IF UNDER 18)	
Name:	Phone:
Relationship to patient:	

HEALTH INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:
Policy Holder Phone #:	Insurance Company Name:

VISION INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:
Policy Holder Phone #:	Insurance Company Name:

General Office Policies

Behavior & Safety: To maintain a safe, respectful, and professional environment for our patients and staff, Premier Eye Associates does not tolerate unprofessional, disruptive, dishonest, or threatening behavior. This includes, without limitation, rude or abusive language, intimidation, harassment, refusal to follow office policies, conduct that makes staff or patients feel uncomfortable or unsafe, behavior that interferes with office operations, knowingly providing false information, or making false or misleading statements, including online. Any violation of this policy may result in immediate dismissal from the practice and cancellation of future appointments.

Consent For Treatment & Communication: I authorize Premier Eye Associates to perform any necessary services that I may need during diagnosis and treatment. I consent to allow office staff to call, text, or email me.

Contact Lenses: If you are having any discomfort or blurry vision with your contact lenses, we will happily recheck your prescription at no cost within 30 days of you receiving your lenses. After 30 days, a new Contact Lens Exam fee and Refraction Fee will be charged.

Goods Sold: All patients are required to pick up all goods purchased within 60 days of notification that the goods are ready for pickup. If goods are not picked up within this time frame, they may be shipped to the address on file, and a $10.00 shipping fee will be added to the patient's account, due upon shipment of the goods.

No-Shows: To ensure fair access to care for all patients, anyone who misses two consecutive appointments without giving 24 hours' notice will no longer be able to schedule future appointments and will be accommodated on a walk-in basis only.

Pregnancy & Nursing: Please inform our doctors if you are pregnant or nursing. For the safety of you and your baby, we ask that you please get approval from your OBGYN before taking any supplements or medications.

Records: All requests for copies of records may take up to 5 business days to process.

Referrals: If a referral is required by your insurance to cover any services or products provided by Premier Eye Associates, it is your responsibility to obtain those referrals prior to your visit.

I agree that I have read, understand, and agree to the above general office policies.

_____ _____

Responsible Party Date

Policies & Practices Agreement

FEES: A $50 fee will be charged for missed appointments or reschedules without at least 24 hours' notice. A $30 fee will be applied for any returned checks. If a credit card dispute is initiated and the patient's claim is denied, a $100 Credit Card Dispute Fee will be charged per dispute to cover administrative and provider time spent responding. The patient will also be responsible for any dispute-related fees assessed by their credit card company. By signing, I agree that I have read, understand, and agree to the previously stated policy.

_____ _____

Patient Signature (Guardian if under 18) Date

GLASSES REMAKES: All remake requests must be submitted within 30 days of the original dispense date. Each pair of glasses qualifies for one complimentary remake and refraction within that 30-day period. Any additional remakes requested beyond the first will incur a 50% remake fee (equal to 50% of the retail lens cost) per remake, as well as a refraction fee if you wish to have your prescription rechecked. By signing, I agree that I have read, understand, and agree to the previously stated policy.

_____ _____

Patient Signature (Guardian if under 18) Date

LATE PAYMENTS, DISPUTES & COMMUNICATIONS AGREEMENT: Effective upon the date of signing below, the Responsible Party agrees to the following: Payment is due at the time of service. Insurance co-payments and deductibles must be paid at the time of your appointment. Any account that becomes delinquent may be sent to collections and will be subject to a $25 late fee. In addition to the $25 late fee, the Responsible Party is responsible for all costs incurred in the collection of any unpaid balance, including collection agency fees of 33.33%, as well as any applicable court costs and attorney fees. These costs remain the Responsible Party's obligation even if payment is made directly to Premier Eye Associates after the account has been turned over to collections. In addition, in the event of any dispute, claim, or legal action arising out of or relating to services rendered, goods provided, billing, payment, refunds, remakes, or these agreements, whether or not such matter involves a delinquent account or collection activity, Premier Eye Associates shall be entitled to recover from the Responsible Party all reasonable costs incurred in connection with such dispute, including attorney fees and court costs. You agree that, for Premier Eye Associates and/or our agents to service your account or collect any monies you may owe, we and/or our agents may contact you by telephone at any number associated with your account, including wireless numbers, which could result in charges to you. We and/or our agents may also contact you via text message or email using any email address you provide. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automatic dialing devices, as applicable. This agreement shall be governed by the laws of the State of Alabama, and any legal action arising from this agreement shall be brought in the county where services are rendered. By signing below, the Responsible Party also waives any right to claim exemption under the laws of Alabama or any other state.

_____ _____

Responsible Party Signature Date

Patient Satisfaction Policy: Your satisfaction is our top priority, and we are committed to providing exceptional, custom-crafted eyewear to support your best possible vision. Lenses are made specifically for each patient and typically take about two weeks to complete, depending on prescription and lens design. If your order is not completed within 30 days of purchase, you will receive a full refund and may keep the eyewear at no cost. Because our products are custom-made, all goods sold and professional services are non-refundable once provided. We ask that eyewear and other goods be picked up within 90 days of notification; items not collected within this timeframe will be considered abandoned and forfeited without refund after two documented contact attempts. By signing below, you acknowledge and agree to this policy.

_____ _____

Patient Signature (Guardian if under 18) Date

Preventative Screenings: At Premier Eye, we are committed to preventing eye disease through early detection and proactive eye care. Our goal is to identify early signs of eye conditions so we can provide the care and education needed to help prevent them from progressing over time. We offer these screenings at a reduced cost to make them accessible to all patients. However, most insurance plans do not cover preventive screenings, as they typically only reimburse for services once an eye disease has been diagnosed. These screenings may include, but are not limited to, retinal imaging and macular health evaluations. Participation in these screenings is entirely optional and not required as part of your eye exam. By signing below, you acknowledge that you have read, understand, and agree to the Preventive Screening Policy, are aware that these screenings are not covered by insurance, and consent to pay privately should you choose to have them performed.

_____ _____

Patient Signature (Guardian if under 18) Date

Insurance: While Patient remains financially responsible for the services and products that Patient receives, including for all applicable co-payments, deductibles or other cost-sharing amounts that are specified by Patient's insurance plans, as well as for all services and products that are determined to be non-covered services under Patient's insurance plans or that exceed the benefit limits under those plans, Premier Eye Associates happily will submit claims to your insurance company. We do our best to estimate your insurance coverage and out of pocket costs, but please remember that it is just an estimate. Ultimately, you are responsible for any outstanding balances. In eye care, two types of insurance may cover your visit, vision insurance or medical insurance. Vision insurance mainly covers routine vision examinations, whereas medical insurance covers exams that address medical issues. Depending on the reason for the examination as well as the exam findings, your exam may be billed to either your vision insurance or your medical insurance, and the applicable co-payments, deductibles and other cost-sharing amounts for that particular insurance will apply. If insurance benefits are used, the claim will be filed at the time of purchase. Once insurance has been submitted and benefits applied, Premier Eye Associates is not responsible for contacting the insurance provider to reverse, cancel, or modify the claim under any circumstance. Patient acknowledges that it is the Patient's responsibility to obtain any referral required by their insurance plan prior to the appointment. Patient further acknowledges that Premier Eye Associates is not responsible for notifying Patient of referral requirements or obtaining referrals on Patient's behalf. In the event insurance denies coverage for any goods or services due to the absence of a required referral, Patient agrees to be financially responsible for all resulting charges. By signing below, you have read, understand, and agree to the previously stated Insurance policy. You are aware of the copays for both your medical and vision

insurances (if applicable) and you authorize Premier Eye Associates to file your claim with the appropriate insurance.

_____ _____

Patient Signature (Guardian if under 18) Date

Notice Of Privacy Rights: We may use and share your health information for treatment, payment, and healthcare operations, including coordination of care, billing, insurance authorization, quality improvement, and required business functions. We may also disclose information as required by law, for public health or safety, abuse or neglect reporting, national security, and appointment reminders. Any other use requires your written authorization. You have the right to access, inspect, and request corrections to your health information, and to request limits or alternative communication methods. You may file a privacy complaint with our office or with HHS without retaliation. Our Office Manager is the Privacy Officer. By signing, you acknowledge receipt and understanding of this notice (Alabama law; venue: Lee County).

_____ _____

Patient Signature (Guardian if under 18) Date

Polycarbonate Lenses: For all patients under 19 years of age and/or patients with reduced vision in one eye, including but not limited to blindness, lazy eye, or amblyopia, our office strongly recommends polycarbonate lenses due to their superior impact resistance and safety. These lenses help reduce the risk of serious eye injury, particularly in children and patients who rely primarily on one eye for vision. I acknowledge and understand the following:

1. I have been informed of the recommendation for polycarbonate lenses and their protective benefits.
2. Choosing lenses other than polycarbonate may increase the risk of serious eye injury, including permanent vision loss or blindness. For patients with only one functional eye, injury to the better-seeing eye could result in severe visual disability or total blindness.
3. Polycarbonate lenses are impact-resistant, not impact-proof, and additional protective eyewear may be necessary for certain activities.
4. If I decline polycarbonate lenses, I understand the associated risks and voluntarily choose an alternative lens material against the recommendation of my eye care provider.

By signing below, I acknowledge that I have read and understand the above information, have been informed of the recommendation for polycarbonate lenses, and understand the potential risks of choosing alternative lens materials, including serious eye injury, permanent vision loss, or blindness. I understand that this recommendation is intended to reduce the risk of serious eye injury and protect vision, particularly in children under 19 years of age and individuals with reduced vision or only one functional eye.

_____ _____

Patient Signature (Guardian if under 18) Date

PREMIER EYE

Authorization to Release Medical Information

Patient First & Last Name: _____ Date of Birth: _____

I hereby authorize medical providers and personnel of Premier Eye Associates to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the office has relied on the use or disclosure of protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient

PREMIER EYE

Insurance & Referrals

Please check one option below.

_____ I verify that I have medical insurance

_____ I verify that I do NOT have medical insurance

Referrals

I understand that if my insurance requires a referral, it is my responsibility to obtain that referral prior to my appointment. I understand that Premier Eye Associates is not responsible for notifying me of any referral requirements or for obtaining referrals on my behalf. If my insurance denies coverage for any goods or services related to my visit due to the absence of a required referral, I understand that I will be financially responsible for all resulting charges.

Responsible Party Name: _____

Signature: _____

Date: _____

==========Staff==========

____ I have received the patients' medical insurance information. This form has been scanned into Crystal.