DEC, LLC DBA
Hauser-Ross
EYE INSTITUTE

CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Hauser Ross Eye Institute. Treatment provided by medical providers, nurses, and medical assistants at Hauser Ross Eye Institute may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Hauser Ross Eye Institute. I understand that all supplies, medical devices and other goods provided to Patient are provided by Hauser Ross Eye Institute AS IS and Hauser Ross Eye Institute disclaims any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities is available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Hauser Ross Eye Institute.

Communicable Disease Testing: I agree that if a Hauser Ross Eye Institute employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to state law, Hauser Ross Eye Institute may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Hauser Ross Eye Institute may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Hauser Ross Eye Institute can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I

take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if a Hauser Ross Eye Institute employee or provider needs to access my pharmacy information that they have my permission to do so.

Non-Discrimination: Hauser Ross Eye Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with scope of sex discrimination described at § 92.101(a)(2)). Hauser Ross Eye Institute does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex. I acknowledge that I have been given a full copy of the Non-Discrimination and Language Assistance Notice, and that I may request an additional copy at any time.

Notice of Language Assistance Services & Auxiliary Aids and Services: Hauser Ross Eye Institute provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services in compliance with Section 1557, including qualified interpreters for individuals with disabilities and information in alternate formats, including but not limited to large print, Braille, recorded audio, and accessible electronic formats, free of charge and in a timely manner, when such modifications are necessary. Hauser Ross Eye Institute also provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, to those with limited English proficiency. I understand and acknowledge that a copy of the full Non-Discrimination and Language Assistance Notice has been provided to me at least annually and/or upon my request and in the language or other format that I require, and that I have the option to opt out of receiving this full notice. I understand that Hauser Ross Eye Institute does not condition the receipt of any aid or benefit on my decision to opt out. I also understand that opting out of receiving the Notice is not a waiver of my right to receive assistance services or auxiliary aids. I acknowledge that should I decide to opt out of receiving the Notice that Hauser Ross Eye Institute will document my decision to opt out in my patient file. I acknowledge that Hauser Ross Eye Institute will document my primary language and any appropriate auxiliary aids and services that I require and will provide those services to me as needed.

Patient's Initials: _____

I consent to receiving my eyeglasses and/or contact prescription electronically via the patient portal. I understand that I can also request a paper copy of my prescription any time after it is finalized in my medical record and that I may revoke this consent at any time.

___Yes ___No

Alternative Contact/Preferred Method of Communication Form:

Patient Name: _____ Date of Birth: _____

We at Hauser Ross Eye Institute take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak with only an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do NOT authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employee of this clinic to speak with:

1. _____ (Name), my _____ (Relationship to patient), their phone number is: _____, regarding my APPOINTMENTS AND ACCOUNT/BILL

2. _____ (Name), my _____ (Relationship to patient), their phone number is: _____, regarding my MEDICAL CARE AND TREATMENT (including Test Results and Lab Results).

Electronic Communication is my preferred method ___Yes ___No

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

Patient's Initials: _____

DEC, LLC DBA
Hauser-Ross
EYE INSTITUTE

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

At Hauser Ross Eye Institute, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a minimum $35 fee per patient, excluding Medicaid patients.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices. Additionally, any outstanding balance will need to be addressed before checking in for an appointment.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-

pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (ie, SSI, disability, etc.).

4. EYE EXAMS & GLASSES: This policy will only apply if you need to purchase eyeglasses and/or contact lenses. You may request a copy of the full policy/procedure for your records.

· One Rx check within 90 days of original exam

· One Rx remake within 90 days of original order date

· One lens remake is allowed during 1 year warranty period

· One frame restyle allowed within 30 days including a fee of $50

· Frames carry a manufacturer warranty against defects for 1 year

· All eyewear and/or contact lens orders must be paid in full prior to submitting to vendor

· All sales are final

5. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination. You will be presented with a waiver acknowledging your acceptance as self-pay, and payment will need to be made at the time of service.

6. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

Patient's Initials: _____

DEC, LLC DBA
Hauser-Ross
EYE INSTITUTE

7. OTHER INSURANCE: I understand that Hauser Ross Eye Institute participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Hauser Ross Eye Institute if I belong to a plan with which Hauser Ross Eye Institute does not participate.

8. NON-COVERED SERVICES: I understand that Hauser Ross Eye Institute contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Hauser Ross Eye Institute to obtain necessary health care service plan authorizations.

9. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Hauser Ross Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Hauser Ross Eye Institute for payment. I understand and agree that if my account is delinquent and sent to collections, I may be charged up to 35% in administrative fees. If the account is

sent to an attorney to assist with collections, I agree to pay collection expenses and reasonable attorney fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Hauser Ross Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Hauser Ross Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I further understand and agree that if I ignore statements of attempts to collect past due amounts, I may have my ability to schedule appointments and/or receive future services from Hauser Ross Eye Institute limited including possible dismissal as a patient from the practice.

Patient's Initials: _____

10. PATIENT STATEMENTS: At Hauser Ross Eye Institute, all accounts are payable within 30 days after you receive your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs. Payments keep your account current only when arrangements have been made. Please call customer service to set up payment arrangements. As a result of costs associated with sending statements, Hauser Ross Eye Institute does not send statements to patients for balances under $20. Billing statements are suppressed until the patient's balance becomes $20 or more in patient responsibility. As a result, you may receive a statement long after your last appointment or may be asked to pay small balances when presenting for an appointment without having received a statement. Patients should remit small balances owed to [PRACTICE NAME] upon receipt of their explanation of benefits from their insurance.

11. PATIENT DISMISSAL: I agree and understand that Hauser Ross Eye Institute may initiate separation and/or dismissal of me as a patient of the practice for any of the following non-exclusive reasons:

(a) Disruptive, aggressive, violent, and/or threatening behavior towards physicians, staff, and/or other patients;

(b) Repeated failure to attend scheduled appointments;

(c) Non-compliance with physician instructions and recommended treatment and/or other erosion of physician/patient relationship; and

(d) Non-payment of past due amounts and/or failure to pay any past due amounts as agreed in any payment arrangement you entered with Hauser Ross Eye Institute. Please note, making payments that are less than an agreed amount per a payment arrangement will be considered and treated as non-payment for purposes of this provision.

Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-out.

Patient's Initials: _____

The physicians and staff at Hauser Ross Eye Institute appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME:
_____

PATIENT'S DATE OF BIRTH:
_____

PATIENT/GUARDIAN SIGNATURE:
_____

DATE: _____ TIME: _____