WestlakeEyeSpecialists
The Art of Eye Surgery

Acknowledgement of Information

PATIENT'S RIGHTS AND RESPONSIBILITIES

I have been given copies of the Patient Rights and Patient Responsibilities of Westlake Eye Specialists. I fully intend to uphold my responsibilities as a patient of this facility and expect my rights as a patient to be upheld.

ADVANCED DIRECTIVES

I have been made fully aware of this facility's policy regarding advanced directives. I have also been made aware of and given information on how to receive information regarding advanced directives.

DISCLOSURE OF OWNERSHIP

I have been made fully aware that the physician performing my procedure may have an ownership interest in a surgical facility. A schedule of typical fees of services provided by that facility is available upon request. These procedures are performed at hospitals and other outpatient facilities in the community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

ASSIGNMENTS OF INSURANCE BENEFITS

Medicare / Other Insurance:

I hereby assign benefits to be paid, on my behalf, to Westlake Eye Specialists. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or another third-party payer. I certify the information given regarding insurance coverage is correct.

Please be aware: If your insurance plan requires a referral and/or authorization for your visit/services, we will make every effort to get the referral from your referring doctor and the authorization from your insurance company. However, it is ultimately your responsibility to know if such a referral and/or authorization is required for your individual insurance plan and to verify that we have received those and have them on file prior to your appointment. Otherwise, you may have to be rescheduled.

Notification:

I received the Patient Rights, Advanced Directives and Disclosure of Ownership information prior to the date of my procedure at the Westlake Eye Specialists.

_____ _____

Printed Name of Patient or Legal Guardian — Date of Birth

_____ _____

Signature of Patient or Legal Guardian — Date

_____ _____

Witness — Date

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

Payment is due at the time of service.

PATIENT AUTHORIZATION – ASSIGNMENT OF MEDICARE AND INSURANCE BENEFITS AND ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I request that payment of authorized Medicare, Medigap or any other insurance be made on my behalf to the Knolle & Young Associates DBA Westlake Eye Specialists for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and other insurers and its agents any information needed to determine these benefits payable for related services. In Medicare assignment cases, or insured contracts, the provider agrees to accept the charge determination of the Medicare carrier or insurance and I am responsible for the deductible, co-insurance (or the 20% Medicare) or insurer does not pay, and for non-covered services (such as the $50 refraction fee not covered by Medicare and most other insurances). I understand that I am responsible for my bill in the event Medicare, or my insurer denies my claim. I authorize the release of my medical records to my primary care physician or other physicians associated with the continuity of my care.

My signature below further verifies that I have not joined an HMO or other entity which my designated insurance (Medicare or Insurance Card) benefits have been relinquished.

I authorize Knolle & young Associates DBA Westlake Eye Specialists, its assignees, and third-party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to Knolle & Young Associates dba Westlake Eye Specialists, its assignees, and third-party collections agents to place calls to my home telephone, cellular telephone, and employment telephone; leave voice messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Additionally, I understand that some that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Knolle & Young dba Westlake Eye Specialists Notice of Privacy Practices. By signing below, I am only giving acknowledgment that I have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Printed Name of Patient or Legal Guardian Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

NOTICE CONCERNING COMPLAINTS

Complaints about physicians as well as other licensees and registrants of the Texas State Board or Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigation, 1812 Centre Creek Dr., Suite 300, P.O. Box 149134, Austin, TX 78714-9134, 1-800-201-9353.

Complaints regarding Knolle & Young dba Westlake Eye Specialists may be registered with the Department of State Health Services Facility Licensing Group, 1100 West 49th St., Austin, TX 78756, 1-888-973-0022.

TDI's Consumer Protection Program helps consumers with insurance questions and problems. The program can be reached toll-free at (800) 252-3439. In addition, the TDI Web Site offers a wealth of information, including a complete listing of licensed agency, agencies and insurers, and records of enforcement and disciplinary actions by TDI as the regulator of the insurance industry.

Consumers with questions and/or complaints about their own insurance claims, agents and/or insurance companies should call the consumer protection line at TDI and can file complaints with TDI. TDI can investigate individual concerns and answers questions. We encourage consumers to also file complaints with the Office of the Attorney General, but please understand that this agency cannot advise you about your specific situation or explain the law. We are prohibited by law from providing these services to private individuals.

The Office of Public Insurance Counsel (OPIC) represents the interests of Texas consumers in matters such as insurance rates and rules. OPIC is required by law to represent all consumers as a group. Individual complaints that suggest a widespread pattern of practices, or which indicate that a large number of consumers are affected, may lead to action by the agency. Therefore, consumers may wish to complain to the OPIC as well.

Westlake Eye Specialists
The Art of Eye Surgery

PATIENT HISTORY

NAME: _____ **DATE:** _____ **DOB:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____ (as stated by pt.) **SEX:** _____ **MALE** _____ **FEMALE**

MEDICAL HISTORY:

- ☐ **Anemia**
- ☐ **Anxiety**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Back/Neck Problems**
- ☐ **Bleeding Disorder**
- ☐ **Bronchitis**
- ☐ **Cancer**
- ☐ **Chest Pain**
- ☐ **Chicken Pox**
- ☐ **Congestive Heart Failure**
- ☐ **COPD**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Emphysema**
- ☐ **ENT Problems**
- ☐ **GI Problems**
- ☐ **Glaucoma**
- ☐ **GYN Problems**
- ☐ **HIV**
- ☐ **Hard of Hearing**
- ☐ **Heart Attack**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis Type**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Kidney/Bladder/Urinary Problems**
- ☐ **Liver Disease**
- ☐ **Measles**
- ☐ **Mumps**
- ☐ **Psychiatric Problems**
- ☐ **Pacemaker**
- ☐ **Palpitations**
- ☐ **Prostate Problems**
- ☐ **Restless Leg Syndrome**
- ☐ **Retina Problems**
- ☐ **Shingles**
- ☐ **Seizures**
- ☐ **Sinus Problems**
- ☐ **Sleep Apnea**
- ☐ **Stroke**
- ☐ **Thyroid Problems**
- ☐ **Ulcers**
- ☐ **Other** _____

☐ **HISTORY OF HEAD OR EYE TRAUMA** (please describe) _____

SURGICAL HISTORY: (list all prior surgeries to best recollection)

_____

_____

_____

Complications with anesthesia? ____ Yes _____ No If yes, what is the complication? _____

FAMILY HISTORY OF OCULAR DISEASE:

- ☐ Macular Degeneration Whom: _____
- ☐ Glaucoma Whom: _____
- ☐ Diabetes Whom: _____

DRUG ALLERGIES: ☐ No Known Allergies ☐ Latex Allergy ☐ Sulfa Allergy ☐ Adhesive Tape

☐ Medication Allergy _____ Reaction _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No PPD: _____ Years: _____

Do you drink alcohol? ☐ Yes ☐ No Drinks Per Week: _____

Substance Abuse? ☐ Yes ☐ No Additional Details: _____

PHARMACY

NAME: _____ LOCATION: _____PHONE: _____

MEDICATIONS

Drug Name	Dosage	Times Per Day

HEALTHCARE PROVIDERS

Rheumatologist / Endocrinologist

Name	Phone
Group or Association	Fax or Direct Messaging Address
Address	Condition(s) Under Management

Other Provider(s)

Name	Phone
Group or Association	Fax or Direct Messaging Address
Address	Condition(s) Under Management

WestlakeEyeSpecialists
The Art of Eye Surgery

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refraction."

WHAT IS A REFRACTION?

A refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

WHEN DOES INSURANCE *NOT* PAY FOR A REFRACTION?

Most health insurance was not designed to pay for non-emergency or routine procedure. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for a refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

WHEN *DOES* PRIVATE INSURANCE PAY FOR A REFRACTION?

Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, a refraction will be performed as part of your eye evaluation. A refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. It is a necessary part of the exam for both medical and legal purposes. In this case, it is possible that the refraction may be covered by your insurance. However, Medicare will not cover a refraction under any circumstances.

WHO HAS MADE THIS DISTINCTION FOR INSURANCE CARRIERS?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefor if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

WHAT IS OUR POLICY?

We are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, a refraction will be performed when medically necessary (typically this includes all new patients, those presenting with decreased vision and on a yearly basis thereafter). Additionally, we are happy to preform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this manner.

Our fee for the refraction is **$50.00**, and is collected at the time of your visit, in addition to any co-payments or deductible amounts due for the medical portion of your examination.

I have been informed, I have read the above and I understand the above policy regarding refractions.

Printed Name _____ DOB _____

Signature _____ Date _____

Witness _____ Date _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

WestlakeEyeSpecialists
The Art of Eye Surgery

NO SHOW / CANCELLATION POLICY

Thank you for choosing Westlake Eye Specialists.

To ensure every patient is taken care of,

reminder **phone calls** will be sent 1-2 days before your appointment, as well as a reminder **text/email message**.

If you are a no show or give less than 48-hour notice of cancellation, there could be up to a **$50.00 charge.**

Please let us know ahead of time of any changes to your appointment.

Thank You!

_____ _____

Printed Name of Patient or Legal Guardian | Date of Birth

_____ _____

Signature of Patient or Legal Guardian | Date

Patient Record of Disclosure

The HIPAA privacy rules give individuals the right to request a restriction on notes and disclosure of their protected health information (PHI). The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I wish to be contacted in the following manner: (check all that apply)

_____ By my home telephone number, my number is: _____

_____ It is okay to leave me a message with detailed information.

_____ It is NOT okay to leave me a message with detailed information.

_____ It is okay to contact me at work, my work number is: _____

_____ It is okay to leave me a message at work with detailed information.

_____ It is NOT okay to leave me a message at work with detailed information.

_____ It is okay to leave a call back number ONLY at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

_____ My spouse, whose name is: _____ Phone: _____

_____ My parent, whose name is: _____ Phone: _____

_____ Other, whose name is: _____ Phone: _____

_____ No one other than myself

_____ _____

Printed Name of Patient or Legal Guardian Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

WestlakeEyeSpecialists
The Art of Eye Surgery

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Social Security #: _____

Sex: _____ Male _____ Female Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed

Race: ___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Emergency Contact Name: _____ Phone #: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Date of Last Eye Exam: _____ Previous Eye Care Provider: _____

REASON FOR TODAY'S VISIT

_____ Cataract Evaluation _____ Routine Eye Exam _____ Surgery to reduce your dependency on glasses/contacts

_____ Other: _____

Please let us know about your history and family history of eye related problems and indicate whom below.

_____ Diabetes Whom: _____

_____ Glaucoma Whom: _____

_____ Age Related Macular Degeneration Whom: _____

HOW WERE YOU REFERRED TO US

Friend / Family / Acquaintance Name: _____

Were you referred by a doctor? Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

_____ TV _____ Radio _____ Magazine Title: _____ _____ Internet _____ Paper

_____ Other: _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

PATIENT'S RIGHTS

1. Patients undergoing surgical procedures in the facilities used by Westlake Eye Specialists have the right to be treated with all due respect, consideration, and dignity. Patients shall be provided appropriate privacy.
2. The patient has the right to be free from all forms of abuse or harassment.
3. Patients have the right to confidentiality. Confidentiality of records of all treatment/procedures performed in the facilities used by Westlake Eye Specialists is the right of each patient. Except as required by law, no patient's medical information will be disclosed to any source without prior legal authorization for approval or refusal from the patient or the patient's legal guardian.
4. Patients have the right to expect proper information. To the best of the knowledge of the Westlake Eye Specialists medical staff, all information concerning the patient's diagnosis, treatment, and prognosis will be provided to the patient. When concern for a patient's health makes it inadvisable to give such information to the patient, such information is made available to an individual designated by the patient or to a legally authorized individual.
5. Westlake Eye Specialists patients are given the opportunity and are encouraged to participate actively in the decision-making process concerning their need for medical and surgical care. Language barriers are dealt with on case-by-case basis through interpreters provided for the patient, language line, and resources available.
6. Patients have the right to expect all procedures and treatments be explained, and the informed consent provided for each surgical procedure be explained prior to being signed by the patient, or patient's legal guardian, and witnessed. Patients are given ample time for discussion and/or questions of the medical staff regarding their treatment. Postoperative instructions are provided, and complication and/or consequences if pre-op and post-op instructions are not followed completely, are discussed with each patient and/or his legal guardian.
7. Patients have a right to request information regarding advanced directives or present their own advanced directive. The patient has a right to the Westlake Eye Specialists policy regarding advanced directives. It is our policy that the advanced directive will be taken to the Medical Director and after discussion, the Medical Director will explain that we do not follow advanced directives in our surgery center. A copy of the directive will be placed in the patient's chart, but it will be ignored. A patient receiving treatment here will always be given emergency, life saving measures if necessary and/or transferred to a hospital with the advanced directive.
8. All patients of Westlake Eye Specialists have the right to address their physician and/or Westlake Eye Specialists administrator should any problems or questions arise relating to the medical nursing care provided and/or subsequent billing for services rendered, without compromise to the patient's future access to care. Each concern so expressed will receive a response and consideration will be given to appropriate corrective action channeled through the Quality Management Committee, Patient Safety Committee, and/or the Board of Directors as needed. Grievances will be addressed within 30 days.
9. Patients have a right to be treated regardless of race, color, creed, gender, or national origin. Requirements for patients' use of the Westlake Eye Specialists facilities are based solely on the medical needs of the patient without regard to race, color, creed, or national origin. All persons having occasion either to refer patients for admission or recommend Westlake Eye Specialists must do so without regard or the patient's race, color, creed, gender, or national origin.
10. Patients have the right to change providers if qualified providers are available. The patient must make request known immediately so an arrangement for rescheduling can be made if necessary.
11. Patients have a right to file any complaints with the Department of State Health Services Facility Licensing Group, located at 1100 West 49th Street, Austin, Texas 78756 1-800-973-OO22. They also file complaints with Medicare by using the website for the Ombudsman: http://www.medicare.

PATIENT RESPONSIBILITES

The patient and/or his family members have the following responsibilities to Westlake Eye Specialists to ensure the best possible results of surgical. intervention:

1. The patient has the responsibility to provide accurate and complete information about present chief complaints, allergies and reactions, illnesses, hospitalizations, medications and dosages, and other matters relating to their health. This includes presenting advanced directives to staff prior to surgery or treatment.
2. The patient has the responsibility to report unexpected changes in condition to the responsible practitioner. Also, the patient should express concern regarding inability to comply with a planned course of treatment, and every effort should be made to adapt the treatment plan to the patient's specific needs and limitations.
3. The patient is responsible for requesting additional information or voicing any concern either prior to the day of surgery or while in the preoperative area prior to anesthesia.
4. The patient is responsible for requesting any information regarding their physician's credentials and/or malpractice coverage. Physicians with no malpractice coverage are not granted privileges in this facility.
5. The patient is responsible for reporting clear comprehension of a contemplated course of action and what is expected of him/her and is responsible for following the treatment plan that is developed with the health care provider.
6. The patient is responsible for keeping appointments and, when unable to do so for any reason, notifying us at (512) 472-4011.
7. The patient is responsible for their own actions if refusing treatment or not following the practitioner's instructions. Noncompliance with the proposed course of treatment may lead to further complications or illness.
8. The patient is responsible for following all preoperative instructions, and for leaving valuables at home and is responsible for providing a responsible adult to transport him or her home from the facility after surgery/treatment.
9. The patient is responsible for being respectful and considerate of the rights of other patients and Westlake Eye Specialists personnel and for assisting in the control of noise and distractions, as well as being respectful of property of others, including the facility.
10. The patient is responsible for adhering to and assisting in the enforcement of the no smoking policy throughout the building.
11. Patients can access all services available using our website, www.westlakeeyes.com, or merely by asking for the information. It is the patient's responsibility to ask any questions on information they need clarified.
12. Fees for services will be addressed with each patient before surgery. It is the patient's responsibility to make payment prior to surgery for what is owed out of pocket. The patient is responsible for all expenses not covered by the insurance company, which will be completely assessed after insurance is billed.
13. Patients have the responsibility to inquire about any questions they have located on post-operative instructions.

NAME OF PATIENT: _____ Today's Date: _____

DOB: _____

Pre-Surgery Visual Functioning VF-8R Patient Questionnaire

Do you have difficulty, even with glasses, with the following activities?
Please select box if Not Applicable or previously had Cataract surgery. [ ]

1. Reading Small print such as labels on medicine bottles?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
2. Reading newspaper or books?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
3. Seeing steps, stairs, or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
4. Reading traffic signs, street signs, or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
5. Doing fine handwork like sewing, knitting, or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
7. Playing games such as bingo, dominos, or card games?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate 3. Great Deal 4. Unable to do the activity
8. Watching Television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	1. Little 2. Moderate Amount 3. Great Deal 4. Unable to do the activity

DATE: _____

NAME OF PATIENT: _____

DOB: _____

Dry Eye Questionnaire

1. Questions about **Eye Discomfort**:
   a. During a typical day in the last month, **how often** did your eyes feel uncomfortable?

[ ] Never		[ ] Sometimes		[ ] Frequent

   b. When your eyes are **uncomfortable**, **how intense** is that discomfort at the end of the day?

N/A		Somewhat		Very
[ ]		[ ]		[ ]

2. Questions about **Eye Dryness**:
   a. During a typical day in the last month, **how often** did your eyes feel dry?

[ ] Never		[ ] Sometimes		[ ] Frequent

   b. When your eyes felt dry, **how intense** is that discomfort at the end of the day?

N/A		Somewhat		Very
[ ]		[ ]		[ ]

3. Question about **Watery Eyes:**
   a. During a typical day, **how often** do your eyes feel watery?

[ ] Never		[ ] Sometimes		[ ] Frequent

4. **Are you currently using lubricating eye drops**?

[ ] Never		[ ] Sometimes		[ ] Frequent

WestlakeEyeSpecialists
The Art of Eye Surgery

Consent to Photography and Videography

The use of photographs and videography is routine in the practice of modern oculoplastic surgery. It plays a vital role surgical planning, and in the documentation of pre-operative, operative and post-operative appearances.

Ordinarily, the captured imagery will be retained in with the patient's medical record, and shared with medical insurers (such as Medicare) as needed in the processing of claims, and in compliance with HIPAA regulations.

In some cases, imagery may be provided to other medical providers if it assists in the coordination of the patient's care. Occasionally, select imagery may be used to facilitate the education of other patients and medical personnel, and it may be used in presentations or publications.

In the course of achieving the above objectives, it is our intention to respect your privacy as much as possible.

I have read and I consent to the above.

_____

Printed Name

_____

Signature & Date

WestlakeEyeSpecialists
The Art of Eye Surgery

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: Insurance doesn't pay for the items or services below, you may have to pay.

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
Tear Osmolarity	Insurance states this procedure is not medically necessary	**$30.00** **Per Test**
Macular OCT	Insurance will not cover if no pathology is found	
Fundus Photo	Insurance will not cover if no pathology is found	
Topography	Insurance will not cover if no pathology is found	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below regarding the testing circled above.

Note: If you choose Option 1 or 2, we may help you by providing customary documentation, to submit to any insurance that you might have, but insurance cannot require us to do this and we will not communicate directly with your insurance regarding this service.

OPTIONS: Check only one box. We cannot choose a box for you.
[ ] OPTION 1. I want the items or services listed above. You may ask to be paid now. I may seek reimbursement from my insurance company for this service. I understand this will be my sole responsibility and that Westlake Eye Specialists will not communicate directly with my insurance regarding this service. I understand that if my insurance doesn't pay, I remain responsible for payment, but **I can appeal the decision of my insurance directly and Westlake Eye Specialists will not be directly involved.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
[ ] OPTION 2. I want the items or services listed above and understand you will not bill my insurance. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if my Insurance is not billed.**
[ ] OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my Insurance would pay.**

****PLEASE SELECT ONE OPTION IN THE BOX ABOVE!!!!

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

Written Financial Policy

Thank you for choosing Westlake Eye Specialists. Our primary mission is to deliver the best and most comprehensive ophthalmic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Options[1] from CareCredit and Alphaeon Healthcare Credit Cards
    - Allow you to pay over-time
    - No annual fees or pre-payment penalties within the promotional period

Please note:

Westlake Eye Specialists requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with health insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment, providing it is a covered service. [2]

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

Westlake Eye Specialists charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the ocular care you want or need.

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

_____

Cardholder Signature Date

_____

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.