**Acknowledgement of Privacy Practices**

Please list the family member(s) or other persons, if any whom we may inform about your medical information and diagnosis (including treatment, payment, health care options):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I have been given the right to review and receive a copy of Kilgore Vision Center’s Notice of Privacy Practices. I understand that Kilgore Vision Center has the right to change this notice, and I may obtain a current copy at any time. I am also acknowledging the Patient Information and History filled out above.

***Will you owe a $30 Refraction Fee?***

A refraction test is performed to determine your eyeglasses or contact lens prescription and involves you answering the questions for the physician “Which is better, # 1 or # 2?”

Medicare and most other insurance plans consider this to be a routine “vision” or “non-medical” service and is NOT COVERED under their medical coverage.

Medicare secondary or supplemental insurance plans will also not pay the charge since it is not a Medicare covered medical service.

*I understand that the refraction test has a fee of $30.00 which must be paid by the patient.*

This fee is in addition to any co-payments, deductibles, co-insurance, or non-covered items as determined by your particular plan. Should your plan pay us for the refraction test, we will reimburse (refund) you accordingly.

\*\**Patients with Davis Vision, Eyemed, VSP, Humana Military (Tricare), or some Arkansas Medicaid plans will not be responsible for the $30.00 refraction fee, as these plans cover a refraction test.*

***Cancellation Policy***

When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed. A late/no-show fee of $25 will be billed to you if you do not give at least 24-hour notice prior to cancellation of your appointment. This notice allows our office staff to schedule another patient who is also in need of medical care.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature patient / guardian Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Print signatory’s name relationship to patient*