Pediatric & Adult Vision Care

Dr. Robert Prazer
Dr. Jonathan Skoner - Dr. Deborah Martin

110 VIP Drive
Suite 301
Wexford, PA 15090
Phone (724) 935-9999
Fax (724) 935-9974

In order for the doctor to see you promptly, it is extremely helpful to fill out the enclosed forms prior to your appointment. Please also take the time to carefully read over our financial agreement and HIPPA privacy policy. They are both located at www.seemybest.com.

Other important items to remember to bring for your evaluation:

- ✓ Insurance Cards
- ✓ Glasses
- ✓ Contact lens prescriptions
- ✓ Copy of most recent eye exam
- ✓ Referring physician letter

Office Hours:
Monday, Tuesday & Wednesday: 10:00am-7:30pm
Thursday & Friday: 8:00am-4:30pm
Saturday: 8:00am-2:00pm

***Staff arrives 30 minutes early for the first appointments of the day.**

Directions to our office:

From the North: Take I-79 South, take Wexford Exit No. 73, turn left on PA 910, and turn left onto VIP Drive. We are in the large white building on the right.

From the South: Take I-79 North, take Wexford Exit No. 73, turn right on PA 910, and turn left onto VIP Drive. We are in the large white building on the right.

From the East: Take I-376 towards I-279, I-279 becomes I-79 North, take Wexford Exit No. 73, turn right on PA 910, and turn left onto VIP Drive. We are in the large white building on the right.

From the West: Take US-22 East towards Pittsburgh, take I-79 North, take Wexford Exit No. 73, turn right on PA 910, and turn left onto VIP Drive. We are in the large white building on the right.

Co-payments and Overages:

Depending on the benefit offered through your insurance plan, you may be responsible for a specialist co-payment and/or overage on the date of your visit. We accept cash, check, debit cards (Visa, MasterCard, and Discover) as methods of payment.

We look forward to seeing you soon. Please do not hesitate to contact us if you have any questions.

Thank you,
Pediatric & Adult Vision Care

PATIENT HEALTH HISTORY & REGISTRATION FORM

Pediatric & Adult Vision Care is implementing an electronic medical record system (EMR). The federal government is requiring health care providers who have adopted EMR to meet specific criteria, which includes asking for this information.

Patient Name: Today's Date _____

First **Last** **MI**

DOB_____/_____/_____ **Age: _____ Gender: _____ Primary Language:_____**

Phone:

Cell **Home** **Work** **Ext**

Address:

Line 1 **Line 2** **City** **Zip**

Last Eye Exam: _____Location of Last Eye Exam: _____ Last Medical Exam:_____

Name of PCP: _____PCP Group/Location: _____

Name of Employer: _____**Occupation: _____**

Medical Insurance Plan: _____ **Vision Plan**:_____

Referred By: _____ Email:_____

Medical History:

Current medications (include over the counter, vitamins, and herbal therapy):

Surgeries (Eye Surgery included):

Allergens/Allergies (e.g. medications, seasonal, latex, eye drops):

Please indicate if any of the conditions apply to your medical history:

Systemic History:	**Yes**	**No**	**Description** (i.e. Date, Treatments, etc.)
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Arthritis	☐	☐	
ADD/ADHD	☐	☐	
Sensory Disorder	☐	☐	
Autism	☐	☐	
Concussion	☐	☐	

Ocular History:	**Yes**	**No**	**Description** (i.e. Date, Treatments, etc.)
Blindness	☐	☐	
Cataracts	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment	☐	☐	
Retinal Disease	☐	☐	
Other_____	☐	☐	

Please indicate if any of the conditions apply to your family history:

Systemic Family History:	**Yes**	**No**	**?**	**Relationship:** (i.e. paternal grandfather, maternal grandmother, father etc.)
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Arthritis	☐	☐	☐	
ADD/ADHD	☐	☐	☐	
Sensory Disorder	☐	☐	☐	
Autism	☐	☐	☐	

Ocular Family History	**Yes**	**No**	**?**	**Relationship** (i.e. paternal grandfather, maternal grandmother, father etc.)
Blindness	☐	☐	☐	
Cataracts	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment	☐	☐	☐	
Retinal Disease	☐	☐	☐	
Other_____	☐	☐	☐	

Review of Systems

Please indicate below if you ***currently*** have any of the following conditions:

Allergic/Immunologic
☐ None
☐ Lupus (SLE)
☐ Sjogren's Syndrome
☐ Environmental Allergies
☐ Other _____

Ear, Nose, & Throat
☐ None
☐ Sinusitis
☐ Ear Infections
☐ Tract Infection
☐ Other _____

Gastrointestinal
☐ None
☐ Crohn's Disease
☐ Colitis
☐ Acid Reflux/Ulcer
☐ Other _____

Skin
☐ None
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Other _____

Psychiatric
☐ None
☐ Depression
☐ Bi-Polar
☐ Anxiety
☐ Other _____

Cardiovascular
☐ None
☐ High Blood Pressure
☐ Vascular Disease
☐ Stroke
☐ Other_____

Endocrine/Glands
☐ None
☐ Diabetes
☐ Hormone Dysfunction
☐ Thyroid Dysfunction
☐ Other_____

Respiratory
☐ None
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Other_____

Muscle/Skeletal
☐ None
☐ Arthritis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Other_____

Genital/Urinary
☐ None
☐ Urinary Tract Infection
☐ HIV Positive
☐ Herpes/Chlamydia
☐ Other _____

Hematologic/Lymphatic
☐ None
☐ Anemia
☐ Leukemia
☐ Bleeding Disorder
☐ Other_____

Neurological
☐ None
☐ Multiple Sclerosis
☐ Epilepsy
☐ Tremors
☐ Other_____

General Health
☐ None
☐ Weight loss/gain
☐ Fever
☐ Fatigue
☐ TBI/Concussion

Social
Tobacco Use:(circle one option below)
Current Smoker Previous Smoker NON Smoker
☐Non-Prescription Drugs_____
☐ Alcohol Consumption_____
Weight_____ Height_____

Please sign below to acknowledge that this history is current and accurate:
(Guardian/Patient) Signature: _____ _____ Date: _____

Please print the guardian name (for patients under 18): _____ Reviewed: _____

Receipt of Notice of Privacy Practices for ***Pediatric & Adult Vision Care*** and ***Vision Therapy***

A copy of our Notice of Privacy Practices is available on our website www.SeeMyBest.com under the office forms tab. Copies are also available in our office. We ask that you please sign below after reading.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below verifies that I have read a copy of the ***Pediatric & Adult Vision Care*** and Notice of Privacy Practices.

Patient name (Print) _____

Patient Signature _____ Date _____

Patient Representative Signature _____
(if patient is a minor or an adult unable to sign this form)

Vision Therapy – Fox Chapel
1380 Old Freeport Road
Suite 1B
Fox Chapel, PA 15238
Phone: 412-963-9090
Fax: 724-799-8315
Email:VisionTherapy@DrPrazer.com

Pediatric & Adult Vision Care
110 VIP Drive
Suite 301
Wexford, PA 15090
Phone: 724-935-9999
Fax: 724-935-9974
Email: info@DrPrazer.com

Vision Therapy - Wexford
110 VIP Drive
Suite 301
Wexford, PA 15090
Phone: 724-799-8313
Fax: 724-799-8315
Email: VisionTherapy@DrPrazer.com

HIPAA Privacy Policy

Effective date of notice: August 1, 2011

Robert W. Prazer O.D., F.C.O.V.D
Jonathan Skoner, O.D., FIAOMC
Deborah Martin, O.D.

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission. [We will ask for special written permission in the following situations:.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

• uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
• disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
• disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
• disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
• uses or disclosures for health related research;
• uses and disclosures to prevent a serious threat to health or safety;
• uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
• disclosures of de-identified information;
• disclosures relating to worker's compensation programs;
• disclosures of a "limited data set" for research, public health, or health care operations;
• incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
• disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
•[specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

• ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.
• ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
• ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.
• ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.
• get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
• get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and posted on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

My signature below verifies that I have read a copy of the ***Pediatric & Adult Vision Care*** Notice of Privacy Practices.

Patient name (Print) _____

Patient Signature _____Date _____

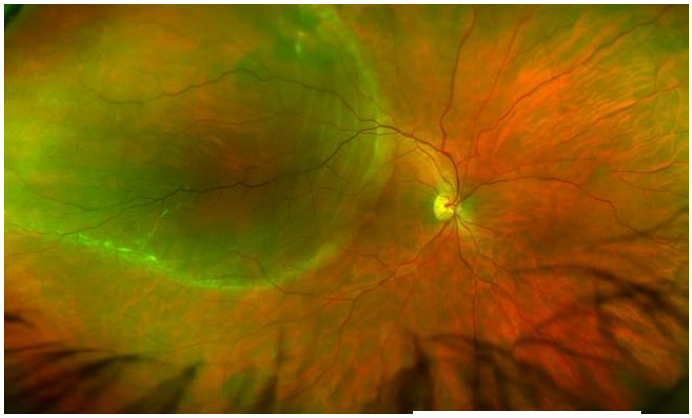
Patient Representative Signature _____
(if patient is a minor or an adult unable to sign this form)

Relationship of Patient Representative to Patient _____

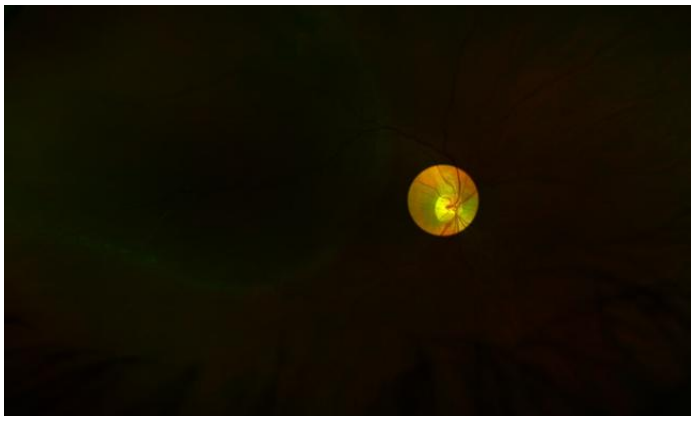
optomap®
ultra-widefield retinal imaging

EARLY DETECTION IS CRUCIAL!

What is the Optomap? An ultra-wide digital retinal imaging device that helps you and your Doctor make informed decisions about your eye health and overall well-being. The scan is fast, easy and comfortable and in most cases, replaces dilation drops which results in blurred vision and sensitivity to light. It provides a **permanent medical record** which gives your Doctor comparisons for diagnosing and tracking potential eye disease. The **Optomap** allows us to capture an unprecedented **200 degree view** of the retina! Compare it below to the view Dilation provides.



optomap® (200°)



Dilation View (30°)

Please print name and select **one (1)** option below: _____

☐ **I elect to have an Optomap.** The Doctors at Pediatric & Adult Vision Care strongly believe that it is in your best medical interest to have an Optomap retinal scan. The Optomap screening fee is only $39 and is not covered by insurance. It is among the most valuable things we do.

Patient Signature _____ *Date* _____

☐ **I elect to have Dilation.** I understand that dilation drops will cause my vision to blur and will make me light sensitive for at least a few hours. These conditions may make it difficult or unsafe to drive. This option may extend my visit by 40 minutes.

Patient Signature _____ *Date* _____

☐ **I do not wish to have the health of my eyes assessed by Optomap or dilation**. I understand that that many of the ocular disease processes do not have symptoms and early detection of ocular health problems is crucial. I fully understand that my decision to decline the Optomap and the dilation drops will limit the Doctor's ability to view my internal eye health.

Patient Signature _____ *Date* _____

A. Notifier: Pediatric & Adult Vision Care 110 VIP Drive, Suite 301, Wexford, PA 15090

B. Patient Name: _____ Date of Birth:_____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: *There may be several charges that your insurance carrier will not cover. These charges must be paid for at the time of your office visit. We will provide you with a detailed receipt of payment.*

Some or all of the following services may be needed and are not payable by your medical, auto or accident insurance:

C.	D. Estimated Cost
Vision & Learning Eval	**$199**
Perceptual Evaluation	**$150**
Optomap	**$39**
Refraction	**$48**
Visagraph Testing	**$45**
Contact Lens Evaluation	**$60-123** **(for most prescriptions)**
Eyeglasses or Contact Lens services	**Charges vary**

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about your care.

E*. Patient (or responsible party) Acknowledgement*:

I have read the notice and am aware that my insurance will not cover the services as detailed above. My signature below acknowledges that I will be making payment for these services on the date services are received.

Signature: _____ Date: _____

PEDIATRIC & ADULT™
VISION CARE

Vision and Learning Evaluation/Functional Vision Evaluation Release

Patient Name: _____ Phone: _____

To ensure continuity of your care, please provide your referring providers contact information allowing our office to communicate your exam findings along with recommended treatment plan.

Name/Title	Mailing Address	Email	Phone

Please list additional professionals with whom to release your exam findings and recommended treatment plan. Please allow 2-3 weeks for the report to be generated and mailed.

Name/Title	Mailing Address	Email	Phone

Release of Information:
I hereby authorize Pediatric & Adult Vision Care to release exam findings and recommended treatment plan regarding myself/my child, _____, to the professionals listed above.

Signature: _____
Print Name:_____
Relationship to patient: self / parent / guardian

30 Symptoms Checklist

Name:_____ Age:_____

After you consider each question, mark the column that applies to the person you are assessing.	Never	Seldom	Occasional	Frequently	Always	Score
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is "I can't" before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks thing over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
					Total Score	

20-24 points=suspect 25 points or more=refer for care

Pediatric & Adult Vision Care
Financial Agreement and Consent to Treatment

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available. In order to familiarize you with the financial policy of this office we would like to explain how your fees will be handled.

The following contains important information concerning your financial responsibilities and your treatment at PAVC. Please read it carefully.

_____ _____

Patient Name (print) *Date*

1. **FINANCIAL AGREEMENT**: I understand payment for services is due in full at the time services are rendered. Eyeglasses and contact lenses must be paid in full at time of order. Services are based on medical necessity therefore, it is impossible for PAVC to provide a total cost prior to evaluation. I understand PAVC will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. I understand that Pediatric and Adult Vision Care does not participate with Medicaid insurance programs. I understand that if my insurance is out of network that I will hold the responsibility for submitting the claim. It is my responsibility to know my insurance benefits and coverage. I am responsible for all co-pays, co-insurances, deductibles, and services or materials not covered by my insurance. In the event it becomes necessary for PAVC to enlist the services of a collection agency and/or legal assistance, I will be responsible for any collection expenses and reasonable fees.

2. **NON-COVERED SERVICES**: I understand that PAVC's agreements with health insurance plans (i.e. HMOs, PPOs) relates only to items and services which are "covered" by the insurance plan. I accept full financial responsibility for all items or services, which are determined by my insurance not to be covered, including the refraction fee.

3. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Pediatric & Adult Vision Care (PAVC) and its clinics for services furnished me by PAVC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the 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 CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. PAVC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.

4. **AUTO INSURANCE and LIABILITY:** We expect that Auto Insurance will not pay for the items or services that are described below. The fact that this insurance does not pay for a particular item or service does not mean that you should not receive it. There are good reasons why your doctor has recommended it. The following items and services below are to be paid by you on the day of service. *These items and services are not limited to the following:*

Items: Materials such as contacts or glasses
Services: Contact lens evaluation, refraction, optomap, and perceptual testing

In the event that the claim goes into litigation the person being treated is responsible for payment of services. We expect you to pay your bill promptly on the day the services are rendered. Once this is done we will fulfill our responsibilities in providing your attorney with necessary medical information.

Proof of financial responsibility is requested prior to services being rendered. Please request proper documentation from the responsible party to be faxed to the office at 724-935-9974. It should include the name of the responsible party, claim number, address, contact person's name along with their phone number.

5**. VOLUNTARY TERMINATION OF CARE:**
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered
by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

6**. AUTHORIZATION TO BILL:** I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Pediatric & Adult Vision Care (PAVC) for services and/or materials rendered. I authorize PAVC to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

7**. AUTHORIZATION TO TREAT**: I also authorize Pediatric & Adult Vision Care(PAVC), its agents, and employees, and their agents and employees (collectively referred to as "Healthcare Providers") to furnish optometric care and services, including but not limited to, diagnostic tests, examinations, dilation and other medical procedures, which are deemed necessary in the course of my care. I understand that PAVC may invite student interns (in training to be Optometry Doctors and Optical Technicians) to assist in providing my care.

Please sign after you have read and reviewed our Financial Agreement and Consent to Treatment.

_____

Patient or Parent/Guardian Signature Date