Low Vision Rehabilitation Service

Universal Consent and Release of Medical Information

Policies and Patient Responsibilities

It is your responsibility to provide our office with accurate and current insurance information. We will bill your insurance as applicable, however, you are responsible for payment if any fees are not covered or paid by your insurance. Although your insurance may confirm benefits, confirmation of benefits is not a guarantee of payment.

It is your responsibility to know the terms of your insurance. If your insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. Co-payments will be collected at the time of service. Professional fees, services fees, co-payments, and deductibles are non-refundable. There is a $20 fee for returned checks. Questions about non-payment should be directed to your insurance company. If your insurance has changed or is terminated at the time of service, you will be financially responsible for the balance in full.

You are financially responsible for any fees associated with any services or products you receive from our office. This includes any medical service, screening, examination, refraction, testing, or contact lens services ordered by the provider. Any request for medical advice or documentation from a provider may be subject to billing including in-person or remote services. A down payment must be made before the devices are ordered.

If you are uninsured or do not plan to submit your claim to your health plan you are entitled to a cost estimate of expected charges before

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receiving services when services are scheduled with 3 days' notice in compliance with the No Surprises Act.

You may be eligible for the cost of the exam and devices to be covered by the Department of Human Services or through other appropriate grants. If you are in need of financial assistance, please request a financial screening with our business manager at 312-997-3672. You may be required to provide documentation demonstrating household income which may include a benefit letter or a tax return.

Refraction

Refraction is the procedure to determine your prescription and magnification need for optical devices, which is an essential part of the examination. This service is considered to be a non-covered service by Medicare and most commercial insurance plans. The fee for this service is **$60** and is collected at the time of the visit, whether there is a change in the prescription. A glasses or optical device prescription is valid for one year from the exam date.

Contact Lenses

If you are interested in contact lens services a separate contact lens agreement must be signed prior to a contact lens fitting or refitting at check-in.

Late Cancellation/No-Show Fee Policy

We require 48 hours notice for cancellations or rescheduling, excluding weekends. Appointment confirmation will be sent by email upon scheduling. As a courtesy, reminder calls are provided 5 days and 2 days prior to the appointment. Cancellations within 48 hours of your appointment time will result in a $25.00 No-show fee. This fee is not

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covered by insurance. We will consider exceptions such as emergencies on a case-by-case basis. After three consecutive no-shows rescheduling must be approved by office manager.

Privacy Practices

All patients are provided with a copy of The Chicago Lighthouse Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, you consent to the use and disclosure of protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, however such revocation shall not affect any disclosures already made. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

For research purposes, your signature gives consent to the review of your records by those authorized by The Chicago Lighthouse and the Institutional Review Board (IRB) for approved retrospective studies.

I have reviewed the policies provided and agree to the terms and conditions.

Printed Patient Name

Patient (or Guardian) Signature **Date**

Witness **Date**

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