Clarus Waiver

At R City Eye Care, we believe in using the most advanced technology to evaluate and manage conditions of the eyes. The Clarus is the latest ultra wide-field digital retinal imaging system, providing our doctors with 200 degree views of the retina in true color. This image will become a part of your permanent health record, enabling early detection of subtle changes from year to year. Clarus imaging is not the same as dilation, but, in most cases, the eyes will not need to be dilated during your routine examination if you have a Clarus image taken. If you have a medical eye condition that requires more advanced imaging, it will be required. The advanced imaging can be filed with your medical insurance, and you will not be charged for the screening image.

______ Yes, I would like to have digital retinal screening performed. I understand that this will cost $29 in addition to my examination fees/copays.

______ No, I would prefer to have my eyes dilated. I understand that my vision will be compromised and that I will have light sensitivity for 4-6 hours.

Signature of patient or personal representative:______________________________ Date:__________

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information, or PHI (Required by the Health Insurance Portability and Accountability Act {HIPAA}, 45 C.F.R. Parts 160 and 164)

1. Authorization
   I authorize R City Eye Care to use and disclose the protected health information described below to (individual seeing the information): ______________________________
2. Effective Period
   This authorization for release of information covers the period of healthcare from:
   a. ☐ ____________________to ____________________ OR
   b. ☐ all past, present, and future periods
3. Extent of Authorization
   a. ☐ I authorize the release of my complete health record OR
   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental Health Records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): ______________________________
4. The person I authorize to receive this medical information may use it for medical treatment or consultation, billing or claims payment, or other purposes I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative ______________________________ Date: __________
Printed name of patient or personal representative ________________________ Relationship:__________

A copy of our full Privacy Policy is available at the front desk.

Today's Date:

PATIENT INFORMATION

Patient Last Name	First	MI	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address	Social Security Number	Date of Birth

City	State	Zip	Cell Phone	☐ Male ☐ Female

Occupation	Employer	Work Phone	Home Phone

Email Address	How do you prefer to be contacted by our office? ☐Text ☐Email ☐Phone call

Referred by (please check one): ☐ Doctor ________________________ ☐ Insurance Plan ☐ Family
☐ Friend ☐ Billboard ☐ Close to home/work ☐ Google ☐ Other ________________________

Other family members seen here:

Primary Care Physician:	Pharmacy:

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person Responsible for Bill	Date of Birth	Address (if different)	Home Phone

Is this person a patient here? ☐ Yes ☐ No	Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: ☐ Medicare ☐ Blue Cross ☐ United Health Care ☐ Other: ____________

Subscriber's Name: ________________________ Subscriber's SSN: ________________ Subscriber's DOB: ______

Please indicate vision insurance: ☐ VSP ☐ VCP ☐ Other:________________________

Subscriber's Name: ________________________ Subscriber's SSN: ________________ Subscriber's DOB: ______

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize R City Eye Care or my insurance company to release any information required to process my claims.

Patient/Guardian Signature: ____ Date: ________________