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This document contains all agreements, disclosures, and notices pertaining to your care and your rights with Haywood Family Eye Care. Please review each section carefully.

SECTION 1: FINANCIAL ASSIGNMENT AND AGREEMENT

I understand that I am financially responsible for all charges incurred for services and products provided by Haywood Family Eye Care. While insurance may be billed as a courtesy, I acknowledge that **any deductibles, copayments, coinsurance, or non-covered charges** remain my responsibility.

I authorize Haywood Family Eye Care to bill my insurance company for services rendered and to receive payment directly from my insurance carrier.

Payment Policy

- **Payment is due at the time services are rendered**, unless prior arrangements have been made.
- **Full payment for all products** — including but not limited to eyeglasses, contact lenses, vitamins, supplements, and other optical or healthcare-related items — is required **before the order is placed or products are dispensed**.
- If insurance is used, **any portion not covered**, including copays, deductibles, or non-covered services or materials, is the patient's responsibility and must be paid **at the time of service**.

SECTION 2: DILATION

As part of your comprehensive eye exam, your doctor may recommend **dilating your pupils** using special eye drops. These drops allow us to fully examine the internal structures of your eyes, which is essential for detecting and monitoring various eye health conditions.

What to Expect:

- **Temporary blurred vision**, especially up close
- **Increased light sensitivity** (sunglasses are recommended)
- Effects typically last **several hours**, but may vary by individual

SECTION 3: ROUTINE VISION VS. MEDICAL EYE CARE - HOW YOUR VISIT IS BILLED

At Haywood Family Eye Care, all eye exams are categorized as either a **Routine Vision Exam** or a **Medical Eye Care Visit**. This classification determines how your visit is billed — **and is based on the outcome of the exam, not your reason for scheduling**.

Routine Vision Exams

Routine vision exams are wellness visits focused on vision correction and eyewear. These are **typically covered by vision plans** or paid out-of-pocket if no vision plan is available. Routine services include:

- **Routine Vision Exam:** Annual check-up to assess overall eye health and vision
- **Near-sightedness (Myopia):** Difficulty seeing objects at a distance
- **Far-sightedness (Hyperopia):** Difficulty seeing objects up close
- **Astigmatism:** Blurred or distorted vision due to an irregularly shaped cornea
- **Need for Glasses:** Updating or obtaining a prescription for eyeglasses
- **Need for Contact Lenses:** Contact lens evaluation and fitting (*may include additional fees*)

⚠ *Vision plans do not cover any medical diagnosis, testing, or treatment.*

Medical Eye Care Visits

Medical eye care involves the evaluation, diagnosis, or treatment of medical conditions. These visits are **billed to your medical insurance**, or are payable out-of-pocket if no insurance is available. Common medical concerns include:

- **Allergies / Dry Eye:** Itching, burning, redness, or gritty sensation
- **Eye Infection:** Pink eye (conjunctivitis), styes, or other infections
- **Cataracts:** Evaluation or ongoing monitoring of lens clouding
- **Diabetic Eye Exam:** Eye health evaluation for patients with diabetes
- **Flashes of Light / New Floaters:** Sudden appearance of bright spots or shadows
- **Glaucoma or Glaucoma Suspect:** Monitoring eye pressure or optic nerve health
- **Medication Monitoring:** Exams related to high-risk medications (e.g., Plaquenil)
- **Optic Nerve / Retinal Conditions:** Diagnosis or management of nerve or retinal issues
- **Amblyopia Treatment:** Management of lazy eye or related vision development issues

🧠 *If medical issues are identified during a routine exam, we are required to classify and bill the visit as medical.*

Who Determines How Your Visit Is Billed?

The **provider determines (and is often dictated by your insurance company based off the outcome of your exam)** whether your visit is routine or medical based on clinical findings during the exam. This is not a patient preference or based solely on your chief complaint.

If you are **self-pay** (without active insurance or vision plan), we will inform you of expected costs based on the final visit type and collect payment at the time of service.

What If You Have Both Medical and Vision Coverage?

If you carry both types of coverage, we may bill each appropriately depending on what services are provided. We use a standard process called **Coordination of Benefits** to help minimize your out-of-pocket costs and ensure proper billing.

SECTION 4: FORMULARY BENEFITS DATA CONSENT

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Manager (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for Haywood Family Eye Care, O.D., PLLC to access my pharmacy benefits data, electronically through Allscripts. This consent will enable Haywood Family Eye Care, O.D., PLLC to:

- Determine the pharmacy benefits and drug co-pays for my health plan
- Check whether a prescribed medication is covered (in formulary) under my plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications

- Determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a historic list of all medications prescribed for me by any provider

SECTION 5: AGREEMENT FOR DIGITAL DELIVERY OF PRESCRIPTIONS

By signing this agreement, you consent to receive both your **eyeglass and contact lens prescriptions** electronically via the secure **Haywood Family Eye Care patient portal**. This consent ensures convenient, immediate, and secure access to your prescriptions once finalized.

1. Digital Delivery Consent

Your finalized eyeglass and contact lens prescriptions will be made available to you **electronically** through our secure online portal. By consenting to this method, you agree that **digital delivery fulfills your right to receive a copy**, unless you specifically request a paper version.

2. Combined Consent for All Vision Prescriptions

This agreement applies to **both** your eyeglass and contact lens prescriptions. Unless otherwise requested, both will be delivered digitally.

3. Special Circumstances

If your condition or treatment does not allow for a standard or "Rx-able" prescription, your provider will inform you. A note will be entered in your medical record explaining why a prescription was not issued.

4. Right to a Paper Copy

You have the right to request a **paper copy** of your eyeglass and/or contact lens prescription **at any time**, free of charge. Simply let us know during your visit or contact our office later.

5. Exceptions and Adjustments

If your prescription cannot be finalized at the time of your visit (e.g., due to dilation or additional testing), it will be completed afterward and then delivered to you electronically.

6. Withdrawing Consent

You may withdraw your consent for digital delivery **at any time**, either in writing or through the patient portal. Once withdrawn, all future prescriptions will be provided on paper unless you reauthorize digital delivery.

7. Data Privacy

Your prescription information will be stored and shared through our **HIPAA-compliant, secure patient portal**. Access is restricted to you and authorized healthcare professionals, in accordance with state and federal privacy laws.

8. Record of Consent

We will maintain a record of this consent in your medical file for **at least three years**, as required by law.

SECTION 6: OFFICE POLICIES

NO-SHOW POLICY:

Please, if you cannot keep an appointment, call and cancel. We prefer that you call 24 hours in advance to cancel or reschedule. It is the policy of the office that you may be discharged from the practice if you have multiple no-shows.

MISSED FIRST APPOINTMENT POLICY:

Patients **new to the practice** who **miss their first scheduled appointment without notice** may **not be allowed to schedule future appointments**. We take your care seriously and ask that you do the same by showing up or giving advance notice if plans change.

LATE ARRIVAL POLICY:

If you are more than 10 minutes late for an appointment, you may be asked to reschedule to another day/time depending upon the schedule of the providers and the reason for your visit.

BEHAVIOR POLICY:

While on the premises or during conversations with our office staff, if a patient/patient representative engages in inappropriate behavior, such as cursing, yelling, derogatory or belligerent attitude/comments or throwing items, the patient and family may be discharged from the practice.

SCHOOL/WORK NOTE POLICY:

Under most circumstances, school/work notes will only be written for the date the patient is seen in the office. A note will be printed upon request at check out.

SECTION 7: NOTICE OF PRIVACY PRACTICES

This **Notice of Privacy Practices** ("Notice") describes how we may use or disclose your health information, and how you can access it. Please read it carefully.

What Is "Health Information"?

For the purposes of this Notice, "health information" refers to any data that identifies you and is created, received, maintained, or transmitted by us during the course of providing health care services.

We are required by the **Health Insurance Portability and Accountability Act (HIPAA)** and applicable state laws to:

- Maintain the privacy of your health information
- Provide you with this Notice outlining our legal duties and privacy practices
- Abide by the terms stated in this Notice
- Notify you in the event of a breach of your **unsecured health information**

How We Use and Disclose Health Information Without Your Authorization

We may use or disclose your health information **without your written authorization** for the following purposes:

1. Treatment

- Scheduling appointments
- Performing exams or diagnostic testing
- Prescribing and transmitting medications
- Referrals to specialists or other providers
- Obtaining records from previous providers

2. Payment

- Verifying insurance eligibility
- Submitting claims to your insurance provider
- Billing you for unpaid balances
- Working with collection agencies if necessary

3. Health Care Operations

- Internal quality assurance
- Licensing and accreditation activities
- Legal and risk management processes
- Participation in managed care plans
- Storage and backup of health records

Other Uses and Disclosures Permitted Without Authorization

We may also disclose your health information in the following scenarios as required or permitted by law:

- **Public health reporting** (e.g., infectious disease, FDA notifications)
- **Abuse, neglect, or domestic violence** reporting to authorities
- **Health oversight activities**, including audits or licensure reviews
- **Judicial and administrative proceedings**, such as subpoenas or court orders
- **Law enforcement purposes**, such as reporting suspected crimes
- **Medical examiner, coroner, or funeral director needs**
- **Organ and tissue donation facilitation**
- **Health-related research** (under approved protocols)
- **Preventing serious threats to health or safety**
- **Specialized government functions**, such as intelligence or military duties
- **Worker's compensation claims**
- **Limited data set disclosures** for research or public health
- **Incidental disclosures** during permissible operations
- **Business associate disclosures** (e.g., billing vendors, labs) with contractual safeguards
- **De-identified information** that cannot reasonably identify you

Unless you object, we may also share relevant health information with **your personal representatives** who are involved in your care. Upon your passing, we may disclose relevant information to your family or others involved in your care unless you instructed otherwise prior to death.

Your Right to Authorize Other Uses and Disclosures

- Any use or disclosure **not described in this Notice** will only be made with your **verbal or written authorization**.
- You may authorize specific individuals (e.g., spouse, caregiver) to receive information relevant to your care.
- You may revoke your authorization **in writing at any time**. This revocation will apply to future disclosures, not those already made based on your previous authorization.
- We are required to honor your request **not to share certain services with your insurance** if you have paid for them **in full out-of-pocket**.

Your Individual Rights

You have the right to:

- **Request restrictions** on how your health information is used or shared
- **Receive confidential communications** (e.g., through a preferred phone or address)
- **Inspect and request copies** of your health information
- **Request amendments** to correct or supplement your health record
- **Receive an accounting** of certain disclosures of your information (up to 6 years prior)
- **Request electronic copies** of your records in a format of your choice (when available)
- **Designate someone else** to receive copies of your health information
- **Be notified of a breach** involving your unsecured health information

To exercise any of these rights, requests must be made **in writing** to the address or email below.

Changes to This Notice

We reserve the right to change our privacy practices at any time and apply the revised Notice to health information we already have. The most current version of this Notice will be:

- Posted on our website at HaywoodFamilyEye.com
- Available at the front desk upon request

Contact Information

If you have questions, requests, or concerns related to your health information, please contact:

Office Manager

✉ Email: office@haywoodfamilyeye.com

Final Agreement and Signature

By signing below, I confirm that I have **read, understood, and agree** to all the terms outlined in this document, including:

- My **financial responsibility** for services and products provided by Haywood Family Eye Care
- The distinction between **routine vision exams** and **medical eye care**, and that visit type is determined by the provider
- How my visit may be billed based on exam findings, and the role of **insurance vs. self-pay**
- The **digital delivery** of my prescriptions through the secure patient portal, unless I request otherwise
- The use of **formulary benefits data** to support prescription accuracy and insurance coordination
- The clinic's **HIPAA-compliant Notice of Privacy Practices**, my rights under the law, and how my health information may be used or shared

I understand that I may request a copy of this agreement and that I may contact the office at any time with questions or concerns.

Patient Name (PLEASE PRINT)

Date of Birth

Signature

Date

Name and Legal Relationship to Patient

(If signed by a parent, legal guardian, or healthcare power of attorney)