



4500 E Cherry Creek S Dr, Ste 1050 Denver, Co 80246

Phone: (303) 691-0777 Fax: (303) 691-0041

Matthew Kruger M.D. • Anthony Kokx M.D. • Kendra Weiler O.D.

CREDIT CARD ON FILE CONSENT FORM

To Our Patients: We have implemented a policy requiring a credit card be held on file effective immediately. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. You are asked for a credit card at the time you check in and the information will be held securely until your insurance has paid their portion and notified us of the amount of your share, then you will receive a statement. This card can be charged for the following reasons:

- Visit payments not collected from you at the beginning of your visit.
- Pending Deductible Non-Covered Charges
- Insurance discrepancies that are not resolved within 90 days of the date of service.
- Outstanding balance greater than 90 days past due.

We now use a service that gives us the ability to swipe your credit card, debit card or health savings account card and accept a payment in the office at the time of service or later. We can use it for future payments including when your insurance company denies the claim. Any deductible pending will be collected at the time of service. We will notify you of your balance due after receiving the explanation from your insurance company.

You will have 48 hours to discuss any questions or concerns, and if we do not hear from you within that time, we will charge your credit card, debit card, or health savings account (HSA) card. Our billing department will send you a receipt of any charges that are made to your card.

The patient hereby acknowledges and agrees that any account that becomes delinquent (after 90 days) will be forwarded to a collection service. See Financial Responsibilities.

Please indicate below how you would like to be notified:

Phone #: _____ OR Email: _____

By signing below, you are agreeing to keep a credit card on file for future payments

Patient Name (Print): _____

Patient Signature: _____



4500 E Cherry Creek S Dr, Ste 1050 Denver, Co 80246

Phone: (303) 691-0777 Fax: (303) 691-0041

Matthew Kruger M.D. • Anthony Kokx M.D. • Kendra Weiler O.D.

REFRACTION FEE

Refraction: \$65 (\$55 if paid at time of service):

One of the most important parts of your eye exam today is the refraction. A refraction is how we test your vision; this is where your doctor determines what, if any, prescriptions are needed to correct or assist your vision. While a refraction is important for a comprehensive eye exam, this charge is only covered by SOME medical insurances as most do not consider this testing as medically necessary.

For vision insurance plans you will be charged additional fees for medical testing.

FTC Eyeglass Regulations:

Under the Federal Trade Commission (FTC) Eyeglass Rule, you are entitled to receive a copy of your eyeglass prescription at the completion of your refraction, whether or not you choose to purchase eyewear from our optical shop. Patients will be asked to indicate their preference regarding how they would like to receive their prescription (printed copy, electronic copy, or declined copy) and acknowledge receipt in accordance with FTC requirements. Our office complies with all FTC prescription release regulations.

Please indicate how you would like to receive your prescription:

- ☐ Printed Copy
- ☐ Electronic Copy
- ☐ Declined Copy

I acknowledge that I am receiving a copy of my glasses prescription in accordance with the Federal Trade Commission (FTC). I have read the above information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I also understand that any copayment, coinsurance or deductible I may have are separate from and are not included in the refraction fee.

Patient Signature: _____ **Date:** _____



4500 E Cherry Creek S Dr, Ste 1050 Denver, Co 80246

Phone: (303) 691-0777 Fax: (303) 691-0041

Matthew Kruger M.D. • Anthony Kokx M.D. • Kendra Weiler O.D.

CONTACT LENS FEE

Contact Lens Fitting and Evaluation (if applicable):

Contact lenses are an alternative to glasses which often provide both functional and cosmetic advantages. They are, however, medical devices which can potentially cause eye problems if they are poorly fit, or cared for improperly. As a contact lens wearer, we provide your ongoing care to insure the best possible visual results, safety and patient satisfaction.

Contact lens fittings and subsequent regular evaluations are additional services and are not included in the cost of your eye exam. Medical insurance does not cover these contact lens related services, but some vision plans do pay for some contact lens fees. All contact lens related follow up appointments within 90 days are included, as are the trial lenses that are dispensed.

Payment for contact lens services and contact lens orders is due at the time services are rendered or when the order is placed, whether in person or by phone.

CONTACT LENS PRESCRIPTIONS ARE VALID FOR ONE YEAR BY STATE LAW

Standard Annual Contact Lens Fees:

Annual contact lens fee (Established): \$50

Refit Fee (Changing brands or types of lenses): \$60

New fit / Teaching fee - Standard contacts: \$100

New fit / Teaching fee - Toric Contacts: \$120

New fit / Teaching fee - Multifocal Contacts: \$130

I acknowledge that I am receiving a copy of my contact lens prescription in accordance with the Federal Trade Commission (FTC) Contact Lens Rule. I understand that contact lens fittings and evaluation services are separate from a routine eye examination and may be considered non-covered services by my insurance plan. I accept full financial responsibility for all contact lens related fees and understand payment is due at the time of service. I further understand that any copayment, deductible, coinsurance, or other patient responsibility required by my insurance plan is separate from and not included in the contact lens fitting fee.

Please indicate how you would like to receive your contact lens prescription:

☐ Printed Copy ☐ Electronic Copy ☐ Declined Copy

Patient Signature: _____ **Date:** _____



4500 E Cherry Creek S Dr, Ste 1050 Denver, Co 80246

Phone: (303) 691-0777 Fax: (303) 691-0041

Matthew Kruger M.D. • Anthony Kokx M.D. • Kendra Weiler O.D.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide and coordinate my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors for my health.
- Conduct normal healthcare operations such as quality assessment and improvement activities.
- Provide services related to our optical shop, including eyewear ordering, fitting, adjustments, repairs, prescription verification, and coordination with vision or medical insurance benefits when applicable.

I hereby acknowledge that I have been given the right to review and receive a copy of this medical *practice's Notice of Privacy Practices*. I further acknowledge that my provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request form. I further understand that Associates in Eyecare, P.C. and/or Peak Optical is not required to accept my restriction request.

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the disclosure of my protected health information to the following individual(s), who are involved in my care or assist with the payment for my care:

Please list the name(s) of the family member(s) or other individual(s) below:

Patient Signature: _____ **Date:** _____



4500 E Cherry Creek S Dr, Ste 1050 Denver, Co 80246

Phone: (303) 691-0777 Fax: (303) 691-0041

Matthew Kruger M.D. • Anthony Kokx M.D. • Kendra Weiler O.D.

PATIENT RESPONSIBILITIES

I, the undersigned, in consideration for services being rendered to the patients by Associates in Eyecare, P.C., and/or Peak Optical understand and agree to the following:

1. I understand that payment for charges, including co-payments, coinsurance, deductibles, non-covered refractions and eyewear materials are due on the date of services are rendered.
2. I hereby authorize Associates in Eyecare, P.C. and/or Peak Optical to file with my insurance carrier and I assign payment of medical and vision benefits to Associates in Eyecare, P.C. and/or Peak Optical.
3. I will keep my account current as to charges for which I am responsible, in the event I fail to pay charges, Associates in Eyecare, P.C. and/or Peak Optical is entitled to take whatever action necessary to collect such charges and I will be responsible for fees incurred as a result of such collection.
4. I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.
5. I understand that my insurance benefits and referral requirements are my responsibility. Associates in Eyecare, P.C. and/or Peak Optical will assist me in any areas possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.
6. I will be sure to inform Associates in Eyecare, P.C. and/or Peak Optical anytime my personal information about insurance coverage changes.
7. The patient hereby acknowledges and agrees that any account that becomes delinquent will be forwarded to a collection service. In the event of default, I agree to pay all collection agency fees 50% on top of outstanding balance and any attorney fees associated with the collection agency. I hereby authorize this provider and its agents, and assignees to contact me via email and phone calls to obtain any balance due.

My signature below indicates that I acknowledge and agree to the set terms above.

Patient Signature: _____ **Date:** _____