

Office Policies

- We are required by law to provide you with our HIPPA Notice of Privacy Practices, which explains how we use and disclose your health information. We are also required to obtain your signature below acknowledging that this notice has been made available to you.
- I hereby give authorization for payment of insurance benefits to be made directly to Dr. Brian E. Colletto O.D. and any assisting physicians, for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits.
- I hereby acknowledge that all services rendered are non-refundable.

By signing below, I understand all the office policies

Signature of Patient _____ Date _____
Printed Name _____ Date of Birth _____
Signature of Parent/Guardian (Minor) _____ Date _____

Dilation

- Dilation allows the doctor to thoroughly examine the inside of the eyes for signs of disease or potential problems which may otherwise go undetected. Dilation last for 3-4 hours. **You will have blurry near vision and sensitivity to bright light during this time.** Most people see well at a distance with their glasses and are able to drive following dilation. If you do not feel comfortable driving while dilated, we can reschedule your dilation when you have available transportation. If you are *pregnant or breast feeding*, your doctor must approve the use of dilation drops.

By signing below, I acknowledge that I understand the importance of dilation and its side effects.

- Yes I grant permission Signature _____ Date _____
 No I defer the dilation Signature _____ Date _____
 Retinal Photos (\$39.00)

Glasses and Contact Lens Policy

- Contact Lens Services are not included in the routine/comprehensive exam fees. **If it is determined that your eyes are unhealthy, the Doctor has the right to refuse a contact lens fit/evaluation.** The contact lens evaluation is a separate evaluation for the ensuring proper fit of your contacts, examing the health of the cornea and evaluating your vision with contacts.
- I understand that after the initial contact lens fitting evaluation that i must return within 30 days for a contact lens follow up. However, if I return for my initial **contact lens follow up** during the following time frames, I will be responsible for the following evaluation fees:
 - After 30 days (**for both glasses and contacts**) ---- \$47.00
 - After 90 days ---- Contact lens evaluation (\$60-\$85)
 - After 6 months (**for both glasses and contacts**) ---- Full comprehensive exam

Signature _____ Date _____