Ludlow Eye Associates
200 Center Street, Suite #1
Ludlow, MA 01056

Patient Name:_____
Patient DOB:_____

Consent for Email/Text Messaging Communications

Patients in our practice may be contacted via email and/or text messaging to provide patient health related reminders/information and/or to remind you of an appointment.

☐ I consent to receiving text messages from the practice to my cell phone. The cell phone number that I authorize to receive text messages is (_____)_____-_____

☐ I consent to receive emails from the practice to my email address. The email that I authorize to receive email messages is _____

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/insurance information/account payments/cost estimates/health information. If you would like to stop receiving text messages/emails, please inform reception or text "STOP" to our phone number. Please be advised that this will stop you from getting any future recall reminders for upcoming appointments.

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

Consent for Optometric Treatment and Financial Responsibility Agreement

I voluntarily consent to receiving optometric treatment at Ludlow Eye Associates. I understand that if I have medical or vision insurance, it will be filed on my behalf. I authorize Ludlow Eye Associates to release all information necessary to my insurance company to secure the payment of benefits. I understand that Vision insurance (Ludlow Eye Associates accepts only VSP and Eyemed vision insurance) covers only routine well-eye exams. These exams are to check for glasses prescriptions and screen for medical conditions. If your routine well-eye exam reveals a medical condition or disease related to your eyes that requires specific counseling, documentation, follow-up care, regular monitoring, prescription of medication, or referral to a surgeon, or if the exam is related to a pre-existing medical condition such as cataracts, glaucoma, diabetes, dry eyes, etc., then your visit is NOT COVERED by your Vision Plan. For instance, if a routine well-eye exam is scheduled simply because you are having difficulty seeing with your current glasses, but it is found that your reduced visual acuity is due to developing cataracts, then your exam would have to be billed to your medical insurance. Unfortunately, the doctor cannot tell if a medical eye conditions exist before you are thoroughly examined. Please note that insurance plan dictated copayments and deductibles then do apply.

The insurance(s) presented at time of service will be the insurance that is (are) billed on my behalf. **Patients are responsible for providing us with accurate and updated billing information at each time of visit. I am aware that Ludlow Eye Associates cannot retroactively bill any insurance that is presented after the date of service.** Ludlow Eye Associates requires the presentation of a valid ID and insurance card at each visit. I am responsible for payment of all applicable copayments, deductibles, and fees for services known to not be covered by insurance, such as contact lens evaluations/new wearer fitting fees and screening retinal photography, at the time of service. Outstanding balances over 90 days may be subject to being sent to collections and any outstanding balances must be paid in full to schedule an appointment for future services. Failure to pay outstanding balances may result in dismissal.

If your insurance company requires you to choose a primary care provider and obtain a referral for your visit, it is your responsibility to do so before the date of service.

If you have any questions about your insurance, please consult your employer or your insurance company directly. I understand that each individual insurance plan is a specific agreement between the plan purchaser (usually the employer and subscriber) and the insurance company. As such, each plan will vary on what they will cover for each insured party, including any exclusions or frequency limitations. There is a $25.00 fee for all returned or insufficient fund checks.

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

No Show Policy

Providing our patients with high quality eye care is our priority. Arriving late or missing a scheduled appointment, called a "no-show", negatively affects our practice and being able to provide patients with high quality comprehensive eye care. It also prevents us from seeing other patients seeking care. You will be considered a "no-show" if you arrive more than 10 minutes late for your appointment without informing us, do not arrive for your appointment, or if you cancel your appointment without a 24 hour notice.

For those who acquire more than 3 "No-show" appointments, you may not be considered for future care at this office. Dismissal will be at the discretion of the provider and only emergency medical care will be provided within 30 days of the dismissal date in order for you to establish care with a new provider.

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not subject to federal or state law protecting its confidentiality. I, _____, also give Ludlow Eye Associates permission to share my protected health information with the following person(s):

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

Optomap Retinal Exams

Our doctors highly recommend the optomap retinal exam as an integral part of your eye exam. Optomap advanced technology assists us in diagnosing diseases like glaucoma, macular degeneration, retinal detachments and other retinal pathologies at a significantly earlier stage than would have been previously detectable. The exam is fast, comfortable, may alleviate the need for dilation, and provides a permanent record for annual review. The exam is not covered by your insurance. The cost of the Optomap Exam is $39.

_____ Yes, I elect to have the Optomap Retinal exam performed today.

_____No, I decline to have the Optomap Retinal exam today and agree to have a dilated fundus exam performed.

_____No, I decline to have the Optomap Retinal exam today and decline to have a dilated fundus exam performed. I understand that declining both of these exams is against the medical advise of the doctors at Ludlow Eye Associates and I assume the risks of any potential irreversible vision loss that may result from not detecting ocular health conditions through a retinal exam.

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

Contact Lens Evaluations & Prescriptions

Contact lenses are medical devices that need to be evaluated annually. Contact lens prescriptions are valid for one year from the day of your evaluation. Evaluation fees are not covered by medical insurance and are in addition to the cost of an eye exam. If you have vision insurance benefits for contact lenses and wish to use the benefit, please let a staff member know and it will be applied to your evaluation fee. **Sign below to acknowledge that you are being provided with a copy of your contact lens prescription at the completion of your contact lens fitting.**

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)

Eyeglass Prescriptions

Ludlow Eye Associates will always provide patients with a physical and/or electronic copy of your eyeglass prescription at the completion of any refractive or routine eye exam. As of September 24, 2024 The Federal Trade Commission requires us to obtain your signature which acknowledges that you are aware of your rights to your prescription. **Sign below to acknowledge that you are being provided with a copy of your eyeglass prescription at the completion of your refractive or routine eye exam.**

Sign:_____Date:_____

Patient Signature (Parent/Guardian if patient is minor)