Rebuck & Associates Eye Care - Glasses and Prescription Policies

Thank you for considering purchasing your eyewear from us. We truly appreciate your business and we do our best to make sure that your glasses will fulfill your needs. The following are our policies on eyewear:

1. If your vision plan makes your glasses for our office, then you are subject to the vision plan's policies on cancellations, prescription changes, remakes, refunds, etc. and you will typically not be able to get glasses made elsewhere under your vision plan until you are eligible again for that benefit in 1 or 2 years.

2. Please realize that it may take time to adapt to your new prescription, so you must try to wear your new glasses as much as possible for **at least two weeks**. If the vision seems strange when you pick them up, then take them home and put them on when you awaken tomorrow. If our practice makes your glasses, then we will remake the lenses once within 60 days of when you received them if you can't adapt to the prescription.

3. All prescription glasses are custom made. Once the lenses are started at our lab, we will not cancel your order or refund your money. Occasionally some patients have chosen a frame, but later decide that they don't like the frame after they receive their glasses. If we can cancel the order for the lenses before they're started, then we will refund 90% of the total frame and lens purchase (We charge a 10% restocking fee). If you want to cancel the order after the lenses are started, then we do not provide refunds. Please make sure that you are satisfied with your choice when your order is placed. We do not provide refunds for buyer's remorse (deciding after you selected your glasses that you no longer want to purchase them).

4. If you decide that you don't like the frame that you chose and the lenses have been started at our lab, we offer you the one time option of having your lenses put into another color of the same size and brand of frame when available. The lenses can't otherwise be used. We will offer you a credit of 60% of the cost of your lenses if you wish to switch to another style of frame after the glasses are made by our lab. If the frame is in brand new condition, then we will provide a full credit toward the cost of another frame from us. The frame you are returning must be the same frame that you purchased from us and be in brand new condition or no credit will be given.

5. Our staff does their best to calculate exactly how much you will owe for your glasses under your vision plan, but occasionally they will not be able to determine that exact amount until the claim has been processed by the vision plan or insurance. Please realize that you are responsible for any amounts indicated by your vision plan and you are financially liable for the entire cost of your glasses if your insurance declines payment for any reason.

6. We will notify you at least twice when your glasses are ready for pickup. The full balance must be paid before you may take them home. If you do not pick them up within 45 days of the first notification, then the lenses will be removed and the frame will be resold and there is no refund. If your vision plan notifies us that you still owe a balance on the glasses even though you already have received the glasses, you will be notified of this bill and you agree to pay the balance within 30 days of notification.

7. It takes significant time and expertise for our staff to make lens and frame recommendations to our customers, so if you need or choose to change to a less expensive lens for any reason, we will remake your lenses once within 30 days, but you will not be refunded the difference in price and you must pay any frame cost above the 90% credited from the initial price of the frame, if you wish to change to another frame.

These policies have been provided to me and I agree to abide by them.

SUMMARY of Notice of Privacy Practices (One page + your signature)

Rebuck and Associates, Office Manager, Dedra Burkhart - 304-725-2020

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). *This Summary is for your convenience and is not a substitute for reading the entire Notice (available upon request) and does not modify the terms of the Notice.*

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may text or leave a message. We may also disclose information to your family about your location and general condition. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, medical research, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes as specified by law.
2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. **You're Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a) You may request restrictions on certain uses and disclosures of your information
    b) You may request that you receive your information from us in a certainway
    c) You may inspect and copy your medical records
    d) You may request an amendment to any record you believe is inaccurate
    e) You may request an accounting of disclosures made of your records
4. **Changes to the Notice**. We reserve the right to change the Notice. If we do so, we will post it in our office, [and on our website] and provide a copy upon request.

5. Complaints. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

R&A
REBUCK & ASSOCIATES
EYE CARE

The following two tests are a vital part of a thorough professional eye examination, and are considered our standard of care. We pride ourselves in providing the utmost patient care so we are now requiring them for all comprehensive examinations.

Optomap Retinal Scan

We capture an extremely high-quality digital photo (of most patients) to see a wide view of the retina to evaluate the health of your eyes. It has enabled us to detect subtle problems that would have otherwise been missed.

The pictures will be kept for comparison at future eye exams and we now require them at every comprehensive eye examination. It typically provides a much better view of the retina even if you are not dilated, but is not a substitution. Dilation is recommended every 2 or 3 years unless you are in a high-risk category (over age 60, diabetic, cataracts, lazy eye, poor vision, etc.)

Ocular Coherence Tomography

This takes a three-dimensional thickness scan of your retina and optic nerve to compare to a normal database and is very sensitive for detecting glaucoma and disease earlier.

These are NOT COVERED BY ANY VISION OR MEDICAL PLAN and cost $50.

Please be prepared to pay this fee at your appointment.

Rebuck & Associates Eye Care - Office Policies

We want you to enjoy your visit with us and you should know that by being examined at our office, you agree to the following policies:

1. If you want your examination to be billed to any type of coverage, then you must present your medical insurance and vision plan cards before we will treat you. If you do not, then we won't bill your insurance and you will have to pay in full on the date of service. We will not bill you later. If you are unable to pay on the date of service, then you must reschedule, unless it is a true ocular emergency. We do offer financing through Care Credit.
2. Vision plans (Davis, Spectera, VSP, Eyemed, etc.) only cover healthy eye exams for nearsightedness, farsightedness, astigmatism, and the need for reading glasses. If you have other eye conditions like cataracts, glaucoma, diabetes, red/pink eye, etc., then your vision plan will not be billed and it must be billed through your medical insurance or paid out of pocket. Your vision insurance will not be billed if your medical insurance denies your claim, except for the refraction/glasses testing charge.
3. Glasses testing/refraction (if your examination is medical in nature) and contact lens evaluations are separate procedures, so both have additional and separate fees, which are not covered by some vision plans or medical insurance. If you desire to get a prescription for contact lenses, then you must have a contact lens evaluation. You have the right to decline the refraction or contact lens evaluation, but you will be unable to order glasses or contact lenses without a current prescription. You can't legally order contact lenses from a glasses prescription. If you are being fit with different contact lenses, then you must return in a timely manner so that your follow up visits are completed within 60 days after you receive your first contact lenses. After this period, you must pay for another fitting at full price.
4. Co-pays must be paid on the date of your examination. If you can't pay your co-pay today, then you will have to reschedule. If we can verify that your medical coverage has an unmet deductible, then you will have to pay towards your deductible today and we will submit a claim to your insurance. After receiving the response from your insurance, we will notify you whether you owe any additional fees or are due a refund.
5. All charges incurred are the financial responsibility of the patient, parent, or guardian regardless if the insurance covers any of the fees. Our staff may attempt to explain your benefits, but we are not insurance experts. You are responsible for knowing what your benefits cover, whether you need a referral and for obtaining a referral prior to your examination. We have to rely on insurance company information which may not be updated.
6. Any balances remaining unpaid after 30 days will accrue 1.5% interest per month. Balances over 60 days may be taken to collections or court. You are responsible for all court costs. If you still don't pay, then this can be reported to credit agencies and this may constitute breach of contract, thus enabling cancellation of your insurance coverage.
7. There may be a charge when requesting copies of your medical records and all balances must be paid before this information will be released.
8. You have a right to your eyeglass prescription and as a patient you will be provided with a copy. Local opticians generally do a good job of filling our prescriptions, but we have some concern with the use of eyeglass vendors over the internet. Fitting eyewear properly involves precise measurements such as PD/pupillary distance and segment height that an internet vendor cannot provide. We provide these measurements at no charge for patients purchasing eyewear from us. If you want these measurements to buy your glasses elsewhere, there will be a $40.00 charge. Payment of this fee entitles you to free adjustments and prescription verification for the glasses.
9. Assignment and release

   I hereby authorize and request that my insurance company pay directly to Rebuck & Associates the amount due in my pending claim for vision or medical treatment or services by reason of such treatment or services. I further assign to Rebuck & Associates all rights afforded to me under ERISA with respect to the services rendered, including the right to bring an action to enforce ERISA and my ERISA rights. I understand that insurance is a private arrangement between me and the insurance company, and that I am fully responsible for all monies due as a result of the services, products, or treatments provided to me by this office. Also, by my signature below, I acknowledge that I received and reviewed a copy of Rebuck & Associates Eye Care, PLLC's Notice of Privacy Practices.

   By signing below, I understand that I am financially responsible for all charges whether or not paid by my vision or medical coverage, have been provided the HIPAA privacy policy, Glasses Policies of this office, and approve OCT/Optos testing as prescribed.

   Print patient name_____ Signature (parent/guardian)_____Date _____

   If the patient is covered under another person's policy please provide their name, date of birth and social security number. Insured's Name_____ Date of Birth _____

   Social security number _____-___-_____ Relationship to patient _____

Speed II Questionnaire for Dry Eye Disease/Ocular Surface Disease

Name: _____ **Date of Birth**: ___/____/_____ Male/Female **Date:** ___/___/___

Dry Eye Disease is the most frequent reason the patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questions below.

Repot the **FREQUENCY** of the dry eye symptoms. How many times are you experiencing the symptoms?

SYMPTOMS	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of the dry eye symptoms

Never = No problems
Tolerable= not perfect but not uncomfortable
Uncomfortable = irritating but does not interfere with my day
Bothersome = irritating and interferes with my day
Intolerable= unable to perform my daily tasks

SYMPTOMS	Never 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark and **X** if you have experienced these symptoms"
Today _____ Within the past 72 hours _____ Within past 3 months _____

Do you use eye drops and/or ointments? YES NO Have you used them today? YES NO
Name of drops:_____ How long are they effective?_____
Do the drops last 4 hours? YES NO Do any gels last 12 hours? YES NO

Are you concerned about fine lines and wrinkles around your eyes? YES NO
Do you have any concerns about skin conditions? YES NO
Did you use Moisturizer, lotions or creams around eyes today? YES NO
Did you use makeup today? YES NO
Have you touched/rubbed your eye(s) today? YES NO If yes, when? _____ , How?_____

Have you ever been told you have BLEPHARITIS? YES NO STYE? YES NO

Do you have fluctuating vision problems (that's gets better with BLINKING)
Never, Sometimes, Frequently, A lot/always

OFFICE USE ONLY
Total Speed Score
(Frequency + Severity) =