PATIENT HIPAA ACKNOWLEDGEMENT AND PHI DISCLOSURE CONSENT FORM

Disclosures to Friends and/or Family Members

On occasion a family member, friend, or caregiver may contact the offices of Dr. Thomas Tsai, O.D., PLLC & Dr. Jana Bertke, O.D., PLLC & Associates to inquire about your medical information. Please list authorized individuals to whom your Protected Health Information (PHI) information may be disclosed.

Authorized Individual	Relationship

Consent to Leave a Voice/Text Messages for Appointment Reminders & Other Healthcare Communications

Patients in our practice may be contacted via phone or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide health or account reminders/ information such as test results, orders and/or referral information.

Circle: I DO / I DO NOT consent to receive voice or text messages from the offices of Dr. Tsai & Dr. Bertke at my cell phone and any number forwarded or transferred to that number to receive communication as stated above. I understand that this request to receive phone or text messages will apply to all future appointment reminders/feedback/account & health information unless I request a change in writing. **Initials:** _____

Authorization to Email Glasses and/or Contact Lens Prescriptions When Requested

Circle: I DO / I DO NOT authorize the office of Dr. Thomas Tsai and Dr. Jana Bertke to e-mail me, or agent of my request, my current glasses or contact lens prescription when requested. I am aware that the office of Dr. Tsai and Dr. Bertke does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By initialing this form and providing my e-mail address, I agree to release and hold harmless Drs. Tsai and Bertke or their employee responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from this office regarding my or my child's personal health information. I further release Dr. Tsai & Dr. Bertke from any liability that may result from using e-mail to communicate with me in the transmission of viruses, malware, ransomware, etc. I understand that reasonable means will be used to protect the security and confidentiality of the email. I understand that this email is for the use of transmitting current glasses or contact lens prescriptions and not for healthcare treatment. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail. The consent will remain in full force until revoked in writing.

E-Mail Address: _____ **Initials:** _____

Notice of Privacy Practices

I acknowledge that I have received the practice's "Notice of Privacy Practices" (given in office or located on the practice's website), which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures.

Signature: _____ Date:_____

(Patient / Parent or Guardian if Patient is a Minor)

FINANCIAL POLICY AGREEMENT

Welcome to Dr. Thomas Tsai, O.D., PLLC & Dr. Jana Bertke, O.D., PLLC. We are pleased you have chosen our practice for your eye care. We ask that you **carefully** read and sign the following policy. We must emphasize that as your medical/vision care provider, our relationship is with **you (the patient/responsible party)** and **not** your insurance carrier. As a courtesy to you, we will file your claim with your primary insurance company if the provider participates in the patient's insurance plan and if you promptly furnish the provider with all correct and complete insurance information. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. **Failure to provide necessary referrals and/or authorizations**, which your insurance company requires **before** care is provided, **or failure to promptly provide current, complete, and accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party**. You are expected to understand your benefits coverage and responsibility. All co-pays, co-insurance, and deductibles are due and payable at the time service is rendered. If we are not filing a claim with your insurance company, or you are a private pay patient, you are responsible for 100% of the payments at the time services are rendered.

You, the undersigned, is fully responsible for all sums due whether or not insurance coverage is available. In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act." In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be **33 1/3%** of such outstanding balance whether suit is filed or not; plus any late fees, garnishment fees, and court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the collection preparation fee of $20 and release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

I certify that I, and/or my dependent(s) have coverage with the above-named insurance and assign directly to Dr. Thomas Tsai, O.D., PLLC and Dr. Jana Bertke, O.D., PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that they do not file with any secondary insurance and I am responsible for filing any secondary or tertiary insurance claims on my own. I authorize that the doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. **I understand that if my insurance plan denies payment, I am responsible to pay for 100% of services rendered in full. I understand that Professional fees (exams, refractions, contact lens evaluations, or any services performed by doctor) are not refundable. I understand that if I have Tricare and a second health/vision plan, Tricare will automatically become secondary and payment is due at time of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and medical record release to health practitioners.**

In consideration of the services performed by Dr. Thomas Tsai, O.D., PLLC & Dr. Jana Bertke, O.D., PLLC now and in the future you agree to abide by the terms of this Financial Statement.

I, the undersigned, certify that I [ ] **am** an active duty member of the U.S. Armed Forces.

[ ] **am not** an active duty member of the U.S. Armed Forces.

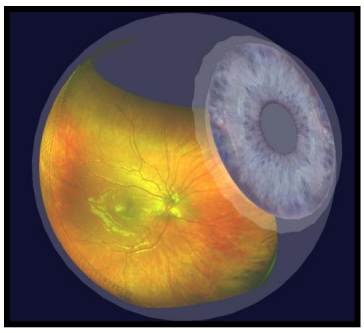
I, the undersigned, certify that I [ ] **will** be using insurance on this visit.

[ ] **will not** be using insurance on this visit.

Signature: _____ Date: _____

(Patient / Parent or Guardian if Patient is a Minor)

DIGITAL RETINAL IMAGE SCREENING AND DILATION CONSENT



As part of a comprehensive eye examination, it is recommended that ALL patients have the internal health of their eyes thoroughly evaluated every year. This is performed as either a dilated retinal exam or digital retinal imaging.

We strongly advise digital retinal imaging and/or dilation for our patients:

-Over 50 Years of Age
-With Nearsighted Vision over -5.00
-First Time Patients to this Office
-Patients with **High Blood Pressure**
-With Histories of Head or Eye injury
-**Family History of Macular Degeneration or Glaucoma**
-Patients with **Diabetes**
-Family History of **Cancer**

These conditions can lead to serious health problems including partial loss of vision or blindness, and *often develop without warning and progress with no symptoms.*

Dr. Tsai and Dr. Bertke are pleased to offer the most highly advanced technology available in eye disease detection, the Optomap Digital Retinal Imaging. The Optomap Digital Retinal Imaging allows them to thoroughly evaluate your internal eye health with dramatically improved precision that includes a depth in the retina not seen with regular dilation.

The **Opto**map® Retinal Imaging Exam:

- Provides your doctor with an in-depth view of the retina to confirm the health of your eye (where disease can start).
- Allows your doctor to detect the presence of disease or other health threatening conditions early in its progression (diabetes and hypertension).
- Provides a permanent record in your medical file enabling your doctor to make important comparisons during your annual eye exam.
- An electronic file of the photograph that can be forwarded to you or another doctor whenever needed.
- Is fast, easy, and comfortable. **Will NOT require dilating drops which result in blurred vision and sensitivity to light for 4-6 hours.** ***Some patients may need to have their eyes dilated also.***

With an annual Optomap, our doctors can track your eye health for concerns, comparison, and treatments. This scan is an essential part of your comprehensive eye exam. There is an additional **$30 copay** for this advanced test**.**

_____ **I ELECT** to have an Optomap Digital Retinal Scan of my retina today.

_____ **I DECLINE** the Optomap Retinal Scan and am **choosing to be dilated** today.

I understand that my vision will be slightly blurry after dilation and light sensitive for 4-6 hours.

_____ **I DECLINE** BOTH the Optomap and dilation at this time.

Signature: _____ Date:_____

(Patient / Parent or Guardian if Patient is a Minor)