Kodiak Vision Clinic
214 W. Rezanof Dr. Suite 1
Kodiak AK, 99615

Eric Noll OD, MBA, FAAO
P: (907) 486-6117
F: (907) 486-6140

Patient Information

Welcome! Thank you for choosing our practice for your eye care needs.
Please take a few minutes to fill out this form. If you have any questions, we will be happy to help.

Full Name______________________________ Nickname____________________
Birthdate __________________ SSN ____________________ Sex □ Female □ Male
Status: □ Married □ Widowed □ Single □ Minor □ Separated
Primary Phone________________________Secondary Phone________________________
Email Address ______________________________May we contact you by email? □ Yes □ No
Mailing Address ______________________ City____________ State_____ Zip code_______
Employer/School__________________Work Phone_______________Occupation/Student:________
Employer/School Address ____________________City____________ State_____ Zip code_______
Spouse/Guardian Name __________________ Primary #_______________ Cell #______________
Emergency Contact ______________ Relationship______________ Phone Number ______________

Ethnicity Information

RACE: □ Asian □ Caucasian □ Hispanic or Latino □ American Indian/Alaska Native
□ Black or African American □ Native Hawaiian or Pacific Islander

Insurance Information

Primary Insurance: ____________________Name of Primary Insured: ____________________
Date of Birth: _____________ Social Security #: _______________ Relationship to patient: __________
Insurance ID Number: __________________________ **Group #:** ________________________
Employer Name: ____

Secondary Insurance: ____________________Name of Primary Insured: ____________________
Date of Birth: _____________ Social Security #: _______________ Relationship to patient: __________
Insurance ID Number: __________________________ **Group #:** ________________________
Employer Name: ____

I understand that my medical records are private and confidential. I understand that by signing this consent form, I authorize KODIAK VISION CLINIC staff to act as my agent in applying for insurance benefits; thus, allowing them to use and release my medical records for medical purposes and for Rx verification between our office and other offices regarding my visits.

I allow the staff of KODIAK VISION CLINIC to disclose any and all information from my records to my insurance company for billing purposes. I also authorize payment of these benefits directly to KODIAK VISION CLINIC.

I understand I can ask for a copy of all my medical records at any time. I also understand to do so I must submit a written and signed request asking so. If I am out of town, I can fax a request to KODIAK VISION CLINIC AND SALLY'S EYELAND at (907) 486-6140.

I have the right to revoke my records being shared between KODIAK VISION CLINIC and any other entities at any time. This revocation must be made by written request, and I understand that any records shared before the revocation was made with my consent.

Signature of Patient/Guardian __________________________________ **Date** __________________

Please turn page over for more

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My signature below confirms that I have been informed of and understand the outlined Eyewear and Financial polices presented to me at my first exam.

Patient or Guardian Signature ____ Date ________

By signing below, I acknowledge I have read this office's HIPAA Compliance Patient Consent and understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ **YES** ☐ **NO**

May we leave a message on your answering machine at home or on your cell phone? ☐ **YES** ☐ **NO**

May we discuss your medical condition with any member of your family? ☐ **YES** ☐ **NO**

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ **Date:** __________________

Witness: ____ Date: ____________________

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Eyewear Policy

Frames

We carry the latest styles, trends, and technology in fashion and safety frames. All of our frames have warranties depending on the manufacturer; please ask our office staff for more information. If your new frame breaks under normal wear-and-tear, we will replace it, one time for free. Should a product become discontinued within the warranty, we will replace the discontinued frame with a new one produced by the same manufacturer. This warranty does not cover accidental damage, scratches, loss, or theft.

Lenses

Lenses are custom made for you, they are non-refundable. It is our policy to remake your lenses (at no cost to you) if the original prescription is incorrect or if you are unable to adapt to a progressive lens. For non-adapt progressive lenses we will make new lenses in any other design that you wish at no charge, within 90 days of dispensing. Original lenses are a custom prescription item which must be discarded. No refunds are issued for the difference in cost if the remake pair is of lesser value. We only use the hardest, most durable surface protection available; however, no lens is deemed scratchproof, any lens can scratch or break. Please follow recommended procedures for care and cleaning. Replacement of lenses purchased with scratch resistant coating is limited to once in a 24-month period, and the original prescription needs to be valid. This warranty does not cover loss or theft.

You may come to our office for as many adjustments and repairs as needed.

Financial Policy

Our goal is to provide the best possible eye health and vision care with our quality products. To help minimize the cost to for patients, please read our financial policy, outlined below.

We accept cash, checks, debit cards, and the most common credit card companies for all our patients' convenience. All returned checks are subject to a $30 Non-Sufficient Funds fee and any other applicable bank fees.

Prescription eyeglasses are considered to be custom orders and are not refundable. Orders are processed at the time of purchase and alterations and cancellations are hard to submit once the order has been forwarded to the lab. Please choose wisely and consider the advice of our trained Opticians.

We will gladly bill patients' primary vision and medical insurance carriers, with whom we have a contract; however, if we are not contracted, we will provide the information needed to submit to insurance for reimbursement. In order for us to bill insurance, please provide us with a current insurance card at the time of service. We cannot be held responsible for knowing all insurance coverages.

We will make every effort to verify your vision coverage; however, the benefits we quote are only estimates. Any difference after the claim has been processed will be the patient's responsibility. All estimated fees are due at the time of service. Please remember that insurance coverage is typically a defined benefit and is not intended to cover the cost of examinations or optical goods in full.

Service charges will be added to all unpaid balances after 30 days. After 150 days, the account will be turned over to collections.

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare
operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health
Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous
usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.