Kaster Eye Clinic

Optical & Vision

1600 E Turkeyfoot Lake Rd, Suite A,
Akron, OH 44312

The Centers for Disease Control and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free-especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment:'

THE CDC RECOMMENDS THE FOLLOWING FOR CONTACT LENS WEARERS:

- Schedule a visit with your eye doctor at least once a year.
- Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.
- Understand that eye infections that go untreated can lead to eye damage or even blindness.

THE FOOD AND DRUG ADMINISTRATION (FDA) INDICATES:

- "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional:'

SYMPTOMS OF EYE INFECTION INCLUDE:

- Irritated, red eyes
- Light sensitivity
- Worsening pain in/around the eyes-even after removal
- Sudden blurry vision
- Unusually watery eyes or discharge.

Sign below to acknowledge that at the completion of your contact lens fitting, you will be provided with a digital copy of your contact lens prescription through your patient portal. A hard copy of your contact lens prescription is also available to you at any time.

Patient Name:_____

Patient Signature: _____

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have been informed that the Notice of Privacy Practices is available for viewing at www.kastereyeclinic.com under the Patient Resources tab or by hard copy in office. Kaster Eye Clinic reserves the right to revise its Notice of Privacy Practices at any time.

Patient/Guardian Initials:_____

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ASSIGNMENT OF BENEFITS

The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Kaster Eye Clinic. I understand that my primary insurance will be billed and that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Patient/Guardian Initials:_____

OPTIONAL - CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Kaster Eye Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

With this consent, Kaster Eye Clinic may call, mail, or e-mail my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any correspondences pertaining to my clinical care, including laboratory test results, among others.

By signing this form, I am consenting to allow Kaster Eye Clinic to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kaster Eye Clinic may decline to provide treatment to me. Other individuals my PHI may be discussed with:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

GLASSES AND CONTACT LENS PRESCRIPTIONS

Please visit our website for important safety information regarding contact lens use and care. Contact lenses are a medical device and misuse can lead to vision impairment or loss. By signing this form, I acknowledge that I will contact Kaster Eye Clinic if I experience any eye pain, discomfort, redness or blurry vision associated with contact lens use.

Sign below to acknowledge that at the completion of your refractive examination and/or contact lens fitting, you will be provided with a copy of your prescription(s). You consent to delivery of your prescriptions digitally through our patient portal. You understand that a hard copy of your prescriptions are available to you at any time by request.

Patient Name: _____

Patient/Guardian Signature: _____ **Date:**_____