



## Practice Policies

### ***Appointment Cancellation & No-Show Policies***

Cancellation Fee: Appointments canceled with less than 24 hours' notice may be subject to a same-day cancellation fee of **\$50.00**.

No-Show Fee: Failure to arrive for a scheduled appointment without prior notice is considered a no-show and may result in a **\$50.00** no-show fee.

No-Show Dismissal: Patients who accumulate **three (3) or more** no-shows may be subject to dismissal from the practice. This determination is made at the discretion of the treating physician

### ***Medical Records Release Policy***

A **\$25.00** processing fee applies to all medical record release requests, including those submitted by disability insurance agencies and law offices. An additional **\$10.00** fee applies for the release of color Fundus photographs and/or copies of OCT or Topography results.

By law, a written and signed authorization from the patient, parent/guardian, or power of attorney is required prior to releasing medical records.

Record release fees may be waived if:

- You move out of state
- You are referred to another physician by an NVOA provider and a record transfer is required.
- We longer take your insurance

### ***Forms Completion Fees***

If extensive forms require completion by our physicians, a **\$25.00** fee will apply.

Completion of a **DMV Eye Exam Report Form** is subject to a **\$20.00** fee.

### ***Minor Consent Policy***

Patients under the age of 18 must be accompanied by a **parent or legal guardian** at the time of the visit.

If a parent or guardian is unable to attend, an **authorized adult** may accompany the minor **only if a signed Minor Consent Form is on file prior to the appointment**. Appointments will be rescheduled if proper authorization is not received.

Minors arriving without a parent, guardian, or authorized adult will not be examined or treated.

### ***Same-Day Family Appointments***

We limit same-day appointments with the same physician to **two (2) family members**. Requests to schedule more than two family members on the same day require **prior approval from the physician**.

### ***Deductible Policy***

For patients with medical insurance, any **unmet deductible** will be collected at the time of service, up to the allowable amount under your insurance contract. This policy applies to **both office visits and surgical services**.

If the deductible is not collected at the time of the visit, a **\$25.00** billing fee will be added once your insurance claim is processed.

For questions regarding this policy, please contact our Billing Department.

### ***Billing & Insurance Responsibility***

Patients are responsible for understanding their insurance coverage, including benefits, referrals, copays, deductibles, and coinsurance amounts.

All patient responsibility balances—including copays, unmet deductibles, coinsurance, and non-covered services—are **due at the time of service**. Required referrals must be provided on the day services are rendered.

### ***Refraction Policy***

Refraction is the measurement used to determine whether glasses or contact lenses are needed. If performed, it is billed using a **routine (non-medical) diagnosis**, such as nearsightedness, farsightedness, or astigmatism.

A new glasses prescription does not need to be issued to warrant this charge.

If your insurance does not cover refraction services, you will be responsible for the cost. The standard refraction fee is **\$70.00**. This fee may be higher for patients with **Aetna insurance** due to contractual requirements.

**Eye Examination Policy**

The eye examination evaluates the overall health of your eyes and will be coded as either:

- **Routine:** No medical eye conditions identified, or
- **Medical:** Presence of conditions such as cataracts, glaucoma, dry eye, double vision, diabetes, or other ocular diseases.

The determination of exam type is made solely by the examining physician.

**Medication History Authorization**

I authorize NVOA to electronically access and review my medication history, including prescriptions from non-NVOA providers, for the purpose of care coordination.

**Use of Medical Scribes**

Some physicians may utilize remote medical scribes. Scribes assist by documenting relevant portions of the visit to ensure accurate and complete medical records. All documentation is reviewed and approved by the physician prior to finalization.

**Notice of Privacy Practices Acknowledgment**

I acknowledge that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have rights regarding the privacy of my protected health information. I understand that my health information may be used to:

- Coordinate, plan, and manage my treatment among healthcare providers
- Obtain payment from insurance carriers or other third-party payers
- Conduct routine healthcare operations, including quality assessments and provider credentialing

I understand that I may review NVOA’s Notice of Privacy Practices, which explains these uses and disclosures in greater detail. I acknowledge that NVOA may update this notice and that I may request a current copy at any time. I understand that I may request restrictions on the use or disclosure of my health information in writing. While NVOA is not required to agree to such restrictions, any agreed-upon limitations will be honored.

**If you choose to list someone under your HIPAA authorization, please provide their name and relationship to you. For minors, a parent(s) or legal guardian must be listed:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I, \_\_\_\_\_ (*Patient name*), have read, understand, and agreed to comply with the above policies:

Patient name (Printed): \_\_\_\_\_ Signature: \_\_\_\_\_

**IF NOT PATIENT:**

3rd Party Name (Printed): \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_