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Dear New Patient or Established Patient,

We would like to make you aware of our office policies.

Your chart information will be maintained under strict privacy in accordance with HIPAA (Health Information Privacy Act). If you object to signing your name on the sign-in sheet, please initial the form and tell the receptionist who you are.

You may have an ocular emergency during a time when I may not be available, such as when I teach at UCLA or when I performing eye surgery. In this type of situation, you may seek care from another ophthalmologist of your choice. I currently share overhead office expense with another physician in my office. You may elect to see him during an emergency or during a period of cross coverage. In your interest, you may give permission to allow him to view your medical records. Please understand that we are not a partnership; treatment, billing, and insurance issues, are completely separate from my practice. It is also important that you realize that I may be a participating provider for an insurance carrier that is not affiliated with another treating ophthalmologist.

Traditional medical insurance does not cover basic refraction for eyeglass prescriptions nor fitting and refraction for contact lenses. The additional fee for refraction is \$75, for contact lens update it is \$100, for contact lens fitting it is \$185, and for contact lens training it is \$125. Payments for these uncovered services are due at the time of service. You may have a separate vision plan that covers refraction and/or eyeglasses. If so please tell us since we do not do retroactive billing. The charge for completing a DMV report, or a disability form, or a brief insurance report is \$25. There is a minimal clerical charge of \$45 for medical records that are copies and/or sent to another party. All appointments rescheduled within 24 hours are subject to a \$45 cancellation fee that may be immediately charged to your credit card on file.

Please be aware that we are not allowed to waive deductibles or co-payments; these are due at the time of service. Copayments not made at the time of service are subject to a \$20 administrative fee. We would like to know if any billing creates a true financial hardship as we do not wish to have any patient's care interrupted.

Please note that dilation of your pupils for an eye examination may blur your vision for at least several hours. It is important to refrain from driving and from performing fine work with tools when your vision is too blurry. You may be given a prescription for a medication refill. It is important that you check with your pharmacist regarding potential interactions with other medications you are taking. Dr. Reynard recommends that you check with www.fda.gov/cder/drug/DrugSafety/DrugIndex.htm to become aware of all potentials risks, benefits, and interactions for all medications you take. We also encourage you to visit our website www.reynardmd.com for information updates and for online appointment scheduling.

Please let us know if there is any change in your address or insurance coverage.

We hope to make your experience pleasant and worthwhile.

I have read the above and agree to its terms and conditions.

PATIENT SIGNATURE: _____ DATE: _____