Drs. Thamel, Ricciardi, Cerio, Thamel & Houston

Vision Source Communication Authorization & HIPAA Authorization

Patient Name: _____DOB_____

Patient Signature: _____ Date_____

I understand that Vision Source may need to contact me regarding appointments, treatment recommendations, test results, billing matters, eyewear and contact lens orders, account balances, and other healthcare-related information. I understand that email, text, and Voicemail messaging may not always be secure forms of communication. By signing below, I acknowledge and accept any associated risks and authorize Vision Source to communicate with me using the methods selected above.

Communication Methods

I authorize Vision Source to communicate with me using the following methods:

- **Text Message**
- **Voicemail**
- **Email**

I would like to opt out of:_____ _____ _____ communication to Vision Source

Individuals I Authorization to Communicate on my behalf (Optional)

I authorize Vision Source to discuss my medical information, appointments, and billing information with the following person:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Drs. Thamel, Ricciardi, Cerio, Thamel & Houston

Notice of Privacy Practices Vision Source of Worcester and Spencer

Patient Name: _____**DOB**_____

Our office maintains the privacy of your protected health information (PHI), and you have access to the full Notice of Privacy Practices posted at the front desk describing how your medical information may be used and disclosed.

By signing below, you acknowledge that:

- You have access to a copy of Vision Source's Notice of Privacy Practices.
- You understand that your health information may be used and disclosed for purposes of treatment, payment, and healthcare operations.
- You understand your rights regarding your protected health information, including the right to request restrictions, access your records, request amendments, and receive an accounting of certain disclosures.
- You understand that Vision Source reserves the right to update its Notice of Privacy Practices. A current copy will be available upon request and on our website.

Acknowledgment

I acknowledge that I have had the opportunity to review Vision Source's Notice of Privacy Practices.

Patient Signature: _____**Date:** _____

If signed by a personal representative:

Representative Name: _____

Relationship to Patient: _____

Signature: _____ Date_____

Policies at Vision Source of Worcester and Spencer

Optomap Imaging

You have chosen a family practice that takes pride in utilizing the latest technology to provide exceptional and comfortable eye care. As a patient of our practice, we use digital wide-field retinal imaging (Optomap) during all comprehensive eye examinations to assess the health of the back of your eye (the retina). Most insurance plans do not cover this technology and carry a fee of **$39.00**, which will be collected at the time of your appointment.

Rescheduling or Canceling an Appointment

If you need to reschedule or cancel an appointment, we ask that you provide at least **48 hours' notice**. We also ask that you confirm your appointment by phone, text message, email, or other electronic communication. If you miss your appointment without providing advance notice, a **$45.00 rebooking fee** must be paid before a new appointment can be scheduled.

Wellness Vision Eye Exam VS Medical Eye Exam

I understand my exam can only be billed through my vision plan if I have no medical conditions that affect my eyes. I understand that if I have medical eye concerns, I will be responsible for my medical copay or deductibles today. Medical visits include: Diabetes, infections, floaters, Dry Eyes, Cataracts, Glaucoma, macular degeneration, allergies, etc.

Diabetic Patients

Annual diabetic eye examinations are an important part of managing your overall health and are often required by your primary care physician and insurance company. We are proud to be part of your diabetic care team and will provide reports to your primary care physician and endocrinologist, when applicable. Because diabetes is a medical condition, diabetic eye examinations are billed to your **medical insurance**, and any applicable copayments, coinsurance, or deductibles will apply.

I have read and understand the policies outlined above.

Patient Signature: _____ Date: _____