NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY & COPAY's

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below. I also acknowledge that my examination today may be billed to my medical insurance vs. vision care program as deemed appropriate by my doctor. I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or Vision Source of GVR.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Vision Source of GVR.

PROFESSIONAL SERVICES AND MATERIALS

I recognize the right to a copy of my prescriptions and am aware it is available via my Personal Health Record account. I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that I am also required to make payment for at least 50% of materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Vision Source of GVR or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

EXTERNAL PRESCRIPTIONS & MATERIALS

I am aware that Vision Source of GVR will not assume any responsibility for the accuracy or quality of any materials made outside of the office. If I choose to have my eyeglasses made elsewhere, I understand it is important to ask for a copy of my eyeglass dispenser's prescription re-make policy so it is clearly defined prior to placing my order. I understand that Vision Source of GVR is more than happy to provide me with eyeglasses or contacts from a valid prescription from an outside provider. For outside prescriptions, I acknowledge there are no refunds or cancellations and the one time remake policy within 90 days of the order will apply.

PATIENT SATISFACTION GUARANTEE

I understand and acknowledge the Vision Source of GVR Patient Satisfaction Guarantee: This guarantee applies to single vision and digital progressive lenses. We recommend using only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame, within 90 days of the original order. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens. We appreciate your understanding in our

inability to ensure the prescription's accuracy to provide you with your best vision possible, and therefore hold our lenses to ANSI (ophthalmic industry) standards as the prescription designates.

FINANCIAL AGREEMENT

I acknowledge that Vision Source of GVR will transfer any outstanding balances to a collection agency sixty (60) days after my initial invoice was generated if I have not contact the office and instituted a payment plan. I understand this action may incur a collection fee of $25 to my overall outstanding balance.

HIPAA

I understand that under the Health Insurance Probability ACT of 1996 (HIPAA), which I have been provided a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

AGREEMENT

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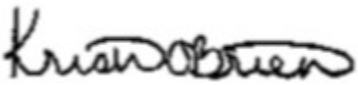
Date

_____

Signature (Guarantor/Patient)

_____

Print Name



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Witness – Kristin S. O'Brien, OD