NOTICE TO ALL PATIENTS:

POLICIES AND PROCEDURES

Eye Care 4 Kids is a charitable 501(c)3, not-for-profit organization. Our clinic is limited, though committed, to helping low to moderate income families in our community receive professional vision services at little to no charge.

Eye Care 4 Kids is not liable for eyeglasses that get damaged during adjustments or repairs. We will not adjust or repair any eyeglass frames that were obtained from a source other than Eye Care 4 Kids.

Since we are a not-for-profit organization, we recommend lined, straight-top, bifocal lenses. Bifocal lenses are much less expensive and generally easier to adapt to. Eye Care 4 Kids does not offer progressive, no-line bifocals.

Eye Care 4 Kids will ask for insurance information at the time of appointment.

The fee structure is as follows:

*Clark County School District (CCSD) students between the ages of 4 and 18+ (as long as the student is enrolled in a traditional CCSD school with a valid ID number; adult school students are excluded) can take advantage of one (1) eye exam at no charge per calendar year, whether in a School-Based Clinic or on the Mobile Vision Clinic, and one (1) pair of eyeglasses, if needed.

*For non-CCSD students (students in private or charter schools) with a sibling in CCSD, they can take advantage of one (1) eye exam at no charge per calendar year, whether in a School-Based Clinic or on the Mobile Vision Clinic, and one (1) pair of eyeglasses, if needed.

*For adults (age 18 and older and no longer in traditional high school), there is a $50 fee for one (1) eye exam and one (1) pair of single-vision eyeglasses.

It is costly to provide these services and Eye Care 4 Kids works diligently to keep the costs in an affordable range for those who would otherwise by unable to afford vision services. All specialty products, added service or replacement items, will be at additional cost to the patient/parent/guardian. If the patient has a high prescription, there will be an additional fee for a reorder of the eyeglasses, if reorder is needed.

Payment is required in full at the time of service. All sales are final and refunds are not offered.

I have read, understand and agree to these conditions. INITIALS: _____

CONFIDENTIALITY NOTICE

Information about your treatment and care is protected by federal law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under this law, the clinic may not disclose any protected information without your written consent except as permitted by federal laws referenced below.

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (i.e. clinical laboratories, pharmacy, billing services, etc.);
3. For research, audit or evaluations;
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the clinic can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Additionally, by signing here, you are also agreeing to the first page of the patient intake form.

Patient signature (minor patient): _____ Date: _____

Signature of Parent or Guardian (for minor patient): _____ Date: _____