Authorization, Consent and Acknowledgement

Financial Responsibility: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of administering claims for insurance benefits. I acknowledge full financial responsibility for the services provided by InVision, LLC and associated providers. I hereby authorize payment of benefits for services described as per assignment designation and assume responsibility for prompt payment of charges in the event of any outstanding balance.

InVision accepts cash, checks, credit/debit cards and HSA flexible spending account cards. There will be a $30 service charge on all returned checks.

Health Insurance Portability and Accountability Act (HIPAA)

I understand that as a part of my health care, InVision, LLC creates and maintains paper and/or electronic describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that as part of InVision, LLC's treatment, payment or health care operations, it may become necessary to disclose and/or request my protected health information to/from another entity, and I consent to such disclosure for these permitted uses, including disclosures via tax.

I recognize that my healthcare providers may have to use their best judgement in some instances where they communicate to others involved in my care.

Additionally, I authorize InVision, LLC to leave information concerning my appointments, billing or financial information, and medical information on my answering machine or voicemail at the phone number(s) I have provided. I understand that receiving information regarding my health can be delayed if messages cannot be left.

I understand that in order to revoke the authorizations about (except to the extent that InVision, LLC has already taken action), I must request this revocation in writing to the Privacy Officer and that until such written document is received, this authorization will be followed. If I do not sign the consent, InVision, LLC may decline to provide services to me.

Dilation Consent

Dilation of the eyes is a diagnostic procedure that allows a more thorough assessment of the internal health of the eyes. If you decide to approve dilation, you need to be aware of the following: You will be sensitive and have trouble with near vision for about 4-8 hours. Your distance vision will most likely be unaffected however you may be more likely be unaffected however you may be more comfortable having someone else drive. There is no additional charge for dilation. If you are diabetic, your insurance may require yearly dilation. Otherwise, we recommend every 2-3 years. Please ask the doctor for more information.