PATIENT POLICIES, PRIVACY NOTICE & CONSENTS

Effective October 14, 2026

Please review these policies and keep them for your records. Complete only the separate acknowledgment page at the end. You may ask questions before signing. Separate informed consent or notices will be obtained when required.

Appointments, Cancellations & No-Shows

Appointment times are reserved for individual patients. Please give at least 24 hours' notice to cancel or reschedule so the time can be offered to another patient.

Office visits: A $25 fee applies to a no-show (missed appointment without notice) or to a cancellation or reschedule with less than 24 hours' notice.

Surgery: A $150 fee may apply when a scheduled surgery is canceled or rescheduled with less than 2 business days' notice.

The same cancellation will not be charged both the $25 office fee and the $150 surgery fee.

These fees are administrative, are not billed to insurance, are nonrefundable, and are not credited toward medical balances.

Where permitted, the fee must be paid before another nonurgent appointment is scheduled.

Fees may be waived at the clinic's discretion for illness, emergencies, medically necessary postponement, or other circumstances beyond the patient's control.

Fees and scheduling restrictions will not be applied where prohibited by law, health plan contracts, or access-to-care requirements.

Financial Responsibility & Payment

Insurance And Patient Responsibility

Clear Vision Clinic (CVC) will submit claims to participating insurance plans when appropriate. Your coverage is a contract between you and your insurer. Benefit verification, referrals, prior authorizations, and estimates do not guarantee payment.

You are responsible for:

- Knowing your benefits and limitations
- Obtaining referrals when your plan requires them
- Presenting a current insurance card and photo ID at every visit
- Telling us promptly about any change in coverage, carrier, member ID, or primary/secondary insurance

If undisclosed or inaccurate insurance information causes a claim to be delayed, denied, or not filed on time, you may be responsible for the charges to the extent permitted by law and your insurance contract. CVC remains responsible for its own claim submission and follow-up, and will not bill amounts that are legally or contractually prohibited.

Arkansas Medicaid

CVC is not enrolled with Arkansas Medicaid and cannot bill Medicaid (including ARHOME and Medicaid managed care plans) for your care. Patients with Medicaid coverage may be seen as self-pay patients only if they agree in writing, before services are provided, to pay CVC directly. Medicaid will not reimburse you or CVC for these services. You may choose instead to receive care from a Medicaid-enrolled provider. Please let our staff know if you have Medicaid coverage when scheduling.

Payment At Time Of Service

Copays, known deductibles, coinsurance, and charges for elective or self-pay services are due at the time of service unless a payment arrangement has been approved in advance. These amounts may be collected before your exam. Your account may be adjusted after insurance processes the claim. Balances assigned to you are due upon receipt of a statement.

Self-Pay, Noncovered & Elective Services

If you do not have applicable insurance, or you choose services your plan does not cover, you are responsible for legally billable charges. Examples include premium cataract lens upgrades and other elective refractive options. Services requiring a new choice at each appointment will be addressed separately during that visit. Elective services with separate charges will be explained before they are provided and may require a separate written estimate, consent, or financial agreement. Medically necessary diagnostic testing is handled under your coverage and applicable advance-notice rules. If you are uninsured or choose not to use insurance, you have the right to receive a Good Faith Estimate of expected charges. Ask our staff for one when scheduling.

Surgery And Procedure Fees

CVC may collect your estimated share for surgery or procedures in advance. CVC and surgeon charges are separate from charges billed by the surgery center, anesthesia provider, laboratory, pharmacy, or other outside entities. Cataract surgery patients will receive a separate financial counseling form explaining expected insurance responsibility and any elective lens upgrade fees. Payment terms for premium lens upgrades are described in the separate premium lens agreement.

Payment Methods

CVC accepts cash, check, ACH, debit card, and credit card as available. Payment arrangements may be offered in limited circumstances. A $25 returned-check fee may be assessed where permitted by law. Failed or reversed electronic payments are handled as permitted by law and disclosed payment terms.

Past-Due Balances And Collections

CVC may ask you to resolve past-due balances or set up an approved payment arrangement before scheduling nonurgent services, where legally and contractually permitted. Unpaid accounts may be referred to an outside collection agency after reasonable billing efforts and notice. Additional collection costs will be charged only where a valid agreement and applicable law permit.

Responsible Parties And Administrative Fees

A legal guardian, representative, or other financially responsible person who authorizes treatment may be responsible for charges as permitted by law. CVC does not resolve financial disputes between family members or other parties. Reasonable fees may apply to forms, letters, and copies of records only where permitted by law, including medical-record access fee limits.

Insurance Authorization & Assignment Of Benefits

I authorize CVC to submit claims and communicate with my insurers about coverage and claims, and I assign payment of insurance benefits directly to CVC where assignment is permitted. I understand I am responsible only for charges that are legally and contractually billable to me. Information needed for treatment, payment, and health care operations may be used or disclosed as HIPAA allows without a separate authorization.

Clinically indicated tests such as OCT, visual fields, and diagnostic retinal imaging may be performed when my provider determines they are needed. Medical necessity does not guarantee coverage. I owe applicable cost sharing and other legally billable amounts. Where an advance notice (such as a Medicare Advance Beneficiary Notice, ABN) is required, CVC will obtain it before the service. This policy does not replace an ABN. Premium lens upgrades and other elective services with separate charges will be discussed and separately authorized in advance.

CLEAR VISION CLINIC

Consent To Routine Eye Examination & Treatment

I consent to examination and medically indicated routine or minor eye care by authorized CVC personnel, including vision and eye pressure checks, slit-lamp and retinal evaluation, dilation when appropriate, OCT, visual fields, retinal imaging, corneal testing, and other noninvasive diagnostic services. I consent to routine exam drops such as dilating drops, numbing drops, and fluorescein.

Dilation can temporarily blur vision and cause light sensitivity; rare adverse reactions can occur. I may decline dilation or any individual service after discussing the risks and limitations with my clinician. The material risks, benefits, and alternatives of minor treatment will be explained.

This general consent does NOT replace specific informed consent for surgery, intravitreal injections, lasers, or other procedures that require separate authorization. No results are guaranteed. This consent remains in effect for future care until I revoke it, consistent with law.

Text Messages & Electronic Communications (Spruce)

If you opt in, CVC may send appointment and surgery details, clinical instructions, medication information, results, follow-up advice, documents or secure links, and billing and insurance messages through Spruce or other approved electronic methods.

Standard text messages and phone notifications may be visible to others with access to your device and may not be fully encrypted. Message and data rates may apply. CVC will use appropriate safeguards and secure methods when appropriate.

Electronic messaging is NOT for emergencies. You may opt out at any time without affecting your care; we may still contact you by other permitted means. Please keep your phone number current. This consent covers health care communications only, not unrelated marketing.

Authorized Contacts

You may name up to two people CVC may speak with about your care or payment, including diagnoses, results, medications, procedures, appointments, and billing. List them on the acknowledgment form, or leave blank if you do not wish to name anyone.

These permissions continue until you change or revoke them. Naming someone does NOT give them authority to make medical decisions for you. CVC will verify identity before sharing information. Other disclosures remain governed by law.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice applies to CVC's patient records and operations.

Your Rights

- Inspect and get a paper or electronic copy of your health records. We generally respond within 30 days; lawful extensions and reasonable fees may apply.
- Ask us to correct inaccurate or incomplete information. If we deny your request, we will explain why and tell you your options.
- Ask us to contact you at a specific phone number or address. We will accommodate reasonable requests.
- Ask us to limit what we use or share. We are not generally required to agree, but we must honor a request not to share information about services you paid for in full out of pocket with your health plan for payment or operations, unless the law requires it.

Ask for an accounting of certain disclosures, and ask for a paper copy of this notice at any time.

- Choose someone with legal authority to act for you, as established by law.
- File a privacy complaint with CVC or with the U.S. Department of Health and Human Services. We will not retaliate against you.

Your Choices

You may tell us your preferences about sharing information relevant to your care or payment with family, friends, or caregivers, or in disaster relief. HIPAA may permit this sharing in limited circumstances without a written designation, consistent with your wishes and the law.

We need your written authorization for most marketing, for any sale of your health information, and for other uses not described in this notice. You can generally revoke an authorization in writing for the future. If we ever send fundraising communications, they will include a way to opt out.

Our Common Uses And Disclosures

- Treatment: coordinating with other clinicians, pharmacies, surgery centers, and referring providers.
- Payment: checking eligibility, submitting and processing insurance claims, and obtaining payment.
- Health care operations: quality management, training, audits, business management, and compliance.

We may also share information when the law permits or requires, including for public health reporting, health oversight, workers' compensation, legal proceedings, law enforcement requests within legal limits, medical examiners, organ procurement, research under appropriate rules, and to prevent a serious threat to health or safety.

Specially Protected Records

Certain records receive extra protection, including substance use disorder treatment records covered by federal law (42 CFR Part 2), if CVC maintains or receives them. These records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your specific consent or a qualifying court order. A consent for treatment, payment, and operations involving Part 2 records does not itself authorize their use against you in legal proceedings. Separate requirements apply to certain counseling notes and to reproductive health, mental health, and other specially protected records under applicable law.

Our Responsibilities

- We must protect the privacy and security of your health information.
- We must follow the terms of the notice currently in effect.
- We will notify you as required if a breach compromises your unsecured health information.
- We will not use or share your information for purposes that require authorization unless you authorize it or another legal exception applies.

We may change this notice for information we maintain. Updated copies will be available in the clinic, on our website, and on request.

Questions And Complaints

Privacy Officer: Melissa Smith, Clear Vision Clinic, 1651 E Stearns St, Suite 110, Fayetteville, AR 72703, 479-425-3541. You may also file a complaint with the HHS Office for Civil Rights at www.hhs.gov/hipaa/filing-a-complaint or 1-877-696-6775. We will not retaliate against you for filing a complaint. Signing the acknowledgment confirms only that you received this notice. It does not waive any of your privacy rights.

General Acknowledgment

You may ask questions before signing. Declining an optional service does not mean declining all care. Please keep your contact and insurance information current. CVC may also ask you to complete a medical history, medication and allergy list, records release, procedure-specific consents, per-visit consents for elective services, premium lens agreements, Medicaid self-pay agreements, or Medicare ABNs when needed. This packet does not replace those forms. Policies may be updated, and material changes will be communicated as appropriate.

CLEAR VISION CLINIC

PATIENT ACKNOWLEDGMENT & CHOICES

Please check one choice per row. Ask us if you have questions.

WHAT I AM AGREEING TO	YES / AGREE	NO
Financial responsibility I agree to pay my legally owed share of charges.	☐ Agree	☐ Decline
Missed / late-canceled office visit A $25 fee applies to a no-show or cancellation under 24 hours.	☐ Agree	☐ Decline
Late surgery cancellation A $150 fee may apply if canceled under 2 business days.	☐ Agree	☐ Decline
Insurance authorization CVC may bill my insurance and receive eligible payment.	☐ Agree	☐ Decline
General eye examination and treatment I consent to routine eye care until I revoke consent.	☐ Yes	☐ No
HIPAA privacy notice I acknowledge receiving the Notice of Privacy Practices.	☐ Received	
Texts and electronic messages I consent to receive texts and electronic messages, including PDFs.	☐ Yes	☐ No
Refraction today — $42 I authorize prescription testing if recommended and may owe $42.	☐ Yes	☐ No
OPTIONAL retinal photos today — $50 Only if I decline dilation; photos do not replace a dilated exam.	☐ Yes	☐ No

Preferred cell number for texts and electronic messages

OPTIONAL AUTHORIZED CONTACTS

Contact 1 Name _____ Relationship _____ Phone _____

Contact 2 Name _____ Relationship _____ Phone _____

I reviewed the policies, had an opportunity to ask questions, and made the choices above.
Fees and patient balances remain subject to insurance requirements and applicable law.

Printed name _____ **Date of birth** _____

Relationship (if representative) _____

Signature _____ **Date** _____