Professional Eyecare

HIPAA Privacy Practice Acknowledgement and Financial Policy

VISION INSURANCE INFORMATION (Patients must present insurance card prior to exam)

Subscriber's Name: _____ DOB: ____/ ____ / _____

Subscriber's Employer: _____ Work Phone: (_____) ____ - _____

Insurance Company: _____ Relationship to Subscriber: _____

Insurance ID #: _____ Group #: _____

MAJOR MEDICAL INSURANCE INFORMATION:

Subscriber's Name: _____ DOB: ____/ ____ / _____

Subscriber's Employer: _____ Work Phone: (_____) ____ - _____

Insurance Company:: _____ Relationship to Subscriber: _____

Insurance ID #: _____ Group #: _____

PRIVACY PRACTICES:

I give my permission to Professional Eyecare to release information about my medical and/or financial to the following person(s) or medical doctor(s) listed here:

Name: _____ Phone: (_____) ____ - _____

Name: _____ Phone: (_____) ____ - _____

My signature confirms that I have been notified that a copy of the **"Notice of Privacy Practices"** of Professional Eyecare is available. I have read and I understand that I am responsible for payment of any balance that insurance will not pay and I authorize Professional Eyecare to provide treatment and to file for my insurance benefits.

_____

Signature of Patient, Guardian or Personal Representative Date

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

_____ _____

Signature of patient or parent, if minor Date

Professional Eyecare adheres to HIPAA privacy regulations and a copy of office policies is available upon request. I wish to review this policy: Yes No

Signature: _____ **Date:** _____