Pickerington Eyecare
Acknowledgement of Privacy Practices

Patient Name: _____ Date of Birth: ____/____/____

The federal law known as the Health Insurance Portability and Accountability Act (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your medical information that we have collected and will collect in the future.

To comply with one of these HIPAA requirements, our Notice of Privacy Practices is posted and a copy is available to you upon request. This Notice of Privacy Practices describes the way we can use/disclose your protected health information and the measures we take to keep it protected. Further, it includes your privacy rights.

It may be necessary for us to make routine disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another optometrist, ophthalmologist or other health care professional in providing or coordinating your treatment. We will get your permission before using your health information for any reason other than these routine disclosures.

By signing below, you acknowledge you are aware of the HIPAA Notice of Privacy Practices of Pickerington Eyecare and that copies of the notice are available for you to take upon your request.

_____ _____

Patient and/or Parent/Guardian Signature Date

_____

Name Printed

Consent for Release of Medical Information

Due to HIPAA regulations, other than the routine disclosures outlined above, we will not be able to discuss any of your medical care and/or treatments with anyone for any reason unless you have authorized us to do so. In order to have such authorization, please select from the following:

[ ] I authorize the release of information including medical care and treatments, medical records and/or examinations rendered to me, and insurance claims information.

[ ] Spouse: _____

[ ] Children: _____

[ ] Other: _____

What is the best phone number to reach you: _____

Pickerington Eyecare
Financial Policy

Our doctors and staff are committed to providing you with thorough, professional eyecare. Your clear understanding of our financial policy is important to our professional relationship.

Fees and Payment Policy

Payment in full is required at the time of your visit and may be made with cash, personal check, money order, Visa, Mastercard, Discover and American Express. Insurance co-payments are due at the time of service. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract. Our staff makes every attempt to obtain an authorization for routine eye exams and materials in advance of your appointment, however, it is your responsibility to contact your insurance company to verify that we are participants in your plan, and the services you intend to receive are covered. In order for us to file a claim, you must present a current copy of your insurance card at each visit and communicate changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services they will not pay for. Therefore we cannot guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

I agree to pay Pickerington Eyecare (in full) within 30 days of notification of nonpayment by my insurance carrier. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made.

Returned Check Charge

Non-Sufficient Funds (NSF) checks are subject to a $30.00 fee (in addition to fees from your bank).

Missed Appointment Charge

We reserve the right to charge a $25 fee for missed appointments without notification.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Patient and/or Parent/Guardian Signature Date