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HIPAA DISCLOSURE/ BILLING AND FINANCIAL POLICY

Insurance Authorization and Assignment:
Our office provides a full scope of eye care services including general vision care (ie: check-ups, glasses and contact lenses), as well as medical eye care services such as treatment for eye infections, dry eye and lid disease, treatment and evaluation of ocular allergy, cataracts, glaucoma and trauma related care. *Depending on the nature of your visit, testing and evaluations necessary we may be able to bill your vision plan insurance, your medical insurance or both.* Please present all of your insurance information to the receptionist upon arrival.

I request that payment of authorized private insurance company benefits and Medicare services or other applicable benefits be paid on my behalf to Clear Vision Family Eyecare for any furnished services.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA):
I authorize Clear Vision Family Eyecare to release any medical or other information about me to any private insurance company, or other company and its agents, which might provide coverage to me. A complete copy of Clear Vision Family Eyecare's Notice of privacy Practices is available for your review and can be furnished upon request.

All Services are the Responsibility of the Patient:
Clear Vision Family Eyecare will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed. If I become aware of insurance coverage after services have been rendered I agree to personally submit the claim to my insurance company for reimbursement. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance. Payments for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer has purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier, *if any required testing is denied or applied to your dollar deductible the fee will become your responsibility.*

Returned Checks:
There is a $25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I AGREE TO ASSUME RESPONSIBILITY FOR FEES INCURRED FOR MY TREATMENT, AS OUTLINED ABOVE.
Patient's Name :_____(please print)
Responsible Party (if not the patient):_____ (please print)

Signature:_____Date: _____

–If you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance and/or payments with (i.e. spouse, parent, etc.)

Name of Authorized Person(s):	Relationship to Patient
_____	_____
_____	_____