

HERITAGE EYE CARE HIPAA PRIVACY NOTICE & DISCLOSURES

In the course of providing services to you, Heritage Eye Care creates, receives and stores health information that identifies you. It is often necessary to use and disclose the health information in order to treat you, to obtain payment for our services, and to conduct health care operations in our office. The *Notice of Privacy Practices (NPP)* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *NPP*, the uses and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes: our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers; as well as other aspects of payment described in our *NPP*. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations and that you also signify that you have been provided with a copy of our *NPP*. Sometimes you may wish to have only certain parts (or medical conditions) of your medical records to be released to only certain physicians or people. **By signing below, I give permission to the person(s) listed in the table documented to receive information about my care. This permission will be considered ongoing until I state in writing otherwise.**

Please list name(s): _____

PATIENT SIGNATURE _____ DATE _____

HERITAGE EYE CARE APPOINTMENT, INSURANCE, AND BILLING POLICY

Billing your insurance is a courtesy provided by Heritage Eye Care. Services billed on your behalf are provided to you on credit, with no guarantee your insurance will cover any or all services provided. Therefore, the financial responsibility for services provided does not belong to your insurance company, but to the person receiving the services—the patient (or guardian). Once your medical insurance has paid according to the terms of their contract, any unpaid balance becomes your responsibility. It is very important that you realize that your insurance is a contract between you, your employer and the insurance company. Heritage Eye Care is not a party to that contract. All charges that you incur are your responsibility from the date that the services are rendered. Heritage Eye Care cannot leave an open balance on your account indefinitely waiting for an insurance company to make payment. There may be times when you will have to pay us directly and settle with your insurance company after the fact. If at any time we receive a payment from your insurance company after you have paid us, you will receive a refund promptly. We cannot waive any co-payments, deductibles or coinsurance amounts defined as patient responsibility under the terms of our contract with these various plans. You will be required to pay your co-pay at every visit, including, but not limited to, any follow-up visits. Accurate, up to date information is the patient's responsibility. You will be asked to show your insurance card at every visit and we also request that you verify your current insurance benefits before each appointment. We mail out statements after the 30th of every month and payment in full must be received by the 20th. After receiving 3 statements, your 4th statement will reflect a \$50.00 late fee and your account may be turned over to collections. We are happy to discuss any balance due, however, you must contact us within 30 days of your 1st statement and you must call your insurance company to verify your benefits before calling us. Please also note that we require a minimum of **24 hours notice** to cancel an appointment. Cancellations less than 24 hours may be billed a late fee after the 2nd time. If you do not call previous to your appointment and fail to show up, you may also incur a fee.

MEDICARE: I request that payment of all authorized Medicare benefits be made either to me, my beneficiary, or Heritage Eye Care for any services furnished to me by them.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I understand and agree to the stipulations of Heritage Eye Care's Appointment, Insurance, and Billing Policy as stated above.

PATIENT SIGNATURE _____ DATE _____