Patient Consent Form

Authorization for use or disclosure of protected Health Information (PHI)

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. By your signature you acknowledge that you have reviewed our notice before signing this consent. A paper copy of the full Notice is available upon request. By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in publication. You have the right to revoke this consent IN WRITING, signed by you. However, such a revocation cannot not be retroactive.

Disclosures that are <u>sent in an unsecured format and may be at risk for accidental disclosure</u>:

May we fax, phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine, voice mail or cell phone YES NO

May we discuss your medical condition with any member of your family? YES NO

May we release a copy of your prescriptions/eyewear? YES NO

I authorize active employees and physicians of Century Eye Care to use and disclose the PHI to the person or persons listed below and will remain in effect until revoked or changed in writing.

Name:____DOB_____________________

Name____ DOB_____________________

Consent Signed by:____

Print Name Please

Signature:____DATE______________________

I understand that information used or disclosed pursuant to this authorization may by disclosed by the recipient and may no longer be protected by federal or state law.

Date:	**Initial:**
_______________	__________
_______________	__________
_______________	__________

PLEASE SEE BACK PAGE

Financial Policy for Century Eye Care

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policy. Please take a moment to review.

We are dedicated to providing quality care and service to you. A complete understanding of your financial responsibilities is essential in what we hope is a long and healthy relationship with our office.

Contracted Insurance

Century Eye Care participates with most major insurance companies including some plans through Medicaid.

In order to submit an accurate claim promptly, an insurance card must be provided at the time of **each** visit.

Today's health insurance policies and coverage offer more options than ever. Each patient is responsible for knowing his/her plan's benefit, co-pay's, co-insurance, deductible, non-covered services and restrictions.

Co-payment/Co-insurance/Deductible

All co-payments, co-insurance and deductibles are due and payable at the time of service per your contractual obligations with your insurance company.

We accept cash, checks and credit cards: Mastercard, Visa, Discover & American Express

No Insurance/Non-Contracted Insurance

If we do not participate with your insurance plan, payment in full is expected at the time of service.

Responsible Party

The adult or legal guardian accompanying the child to a visit is responsible for full payment (regardless of the insurance coverage) and will be set up as the person who will receive the bill (guarantor). Century Eye care will not be involved in negotiating between parents/guardians in disputes.

Monthly Statements

Statements are mailed monthly. All patient balances are due within 30days upon receipt. Accounts with unpaid balances over 60 days may be subject to additional fees.

Accounts with an outstanding balance more than 60 days overdue must make arrangements with the business office prior to scheduling appointments.

Return Checks

A $35 charge will be added to your account for any check returned by your bank for any reason.

I acknowledge that I have reviewed the Financial Policy for Century Eye Care.

Signature:____**Date**__________