BUTLER EYE CARE, LLC	CHICORA EYE CARE
391 EVANS CITY ROAD	104 WEST SLIPPERY ROCK STREET
BUTLER, PA 16001	CHICORA, PA 16025
(724) 283-8144	(724) 445-3901

I have been made aware of the *Notice of Privacy Practice (HIPAA)* that Butler Eye Care, LLC / Chicora Eye Care is required to maintain the security of these records, certain limits and protections for treatment, payment, and healthcare operation activities. I authorize to receive treatment for services from Butler Eye Care, LLC / Chicora Eye Care.

I authorize the provider to release any information necessary to adjudicate the claim. I understand and personally guarantee payment of the balance of any Medical / Vision services and materials not covered by my insurance carrier that will be provided. Upon submission to my insurance carrier, I will be notified of any additional balance due.

Payment Terms and Conditions

1. Butler Eye Care, LLC / Chicora Eye Care has a 2% service charge for all statements that are over 30 days past due and will be charged for each additional 30-day period.
2. Butler Eye Care, LLC / Chicora Eye Care has a $35.00 NO SHOW fee.
3. Butler Eye Care, LLC / Chicora Eye care has a $50.00 fee for any NSF Checks.

Over 18 HIPAA authorization assignment:

I authorize the provider to disclose my complete eye care record to _____.
This information may be used by the person authorized for medical treatment, consultation, billing or claims payments, or other purposes as I may direct. I understand that I have the right to revoke this authorization in **WRITING** at any time. I understand that the revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed by the recipient and may no longer be protected by federal or state law.

Print: _____   Date: _____

Signature: _____ Relationship to the Patient: _____