BUTLER EYE CARE

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I have been made aware of the *Notice of Privacy Practice (HIPAA)* that Butler Eye Care, LLC 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.

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 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 has a $35.00 NO SHOW fee for any missed appointments not rescheduled prior to appointment time.*
3. *Butler Eye Care, LLC has a $50.00 fee for any NSF Checks.*
4. *The patient is responsible for any balance not covered by insurance, or lack of insurance, including copays at the time of services rendered.*
5. *The patient is responsible to pay outstanding balances owed on any ordered materials at time of dispense, within 90 days or said balance will be placed with collections.*

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: _____