BUTLER EYE CARE

Michael McGrath, O.D.
Jennifer McGrath, O.D., F.A.A.O.
Danielle Cozza, O.D.
Robert Wheatall, O.D.

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 operations activities. I am authorized 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 for 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 5% 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 NO SHOW fee for any missed appointments not rescheduled or canceled prior to the appointment time.*
3. *Butler Eye Care, LLC has a $50 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 are rendered.*
5. *The patient is responsible to pay outstanding balances owed on any ordered materials at the time of order, or the order will be canceled due to non payment.*

Over 18 HIPAA authorization assignment:

I authorize the provider to disclose my complete medical 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 contrast a claim. I understand that information used or disclosed by the recipient may no longer be protected by federal or state law.

Print: _____ Date: _____

Signature: _____ Relationship to patient: _____