Optometric Care Associates

1112 Vine St Paso Robles, CA 93446
Ph: (805) 238-1001 Fax: (805) 237-1057

2231 Bayview Heights Dr Los Osos, CA 93402
Ph: (805) 528-5333 Fax: (805) 528-7723

8105 Morro Rd Suite A Atascadero, CA 93422
Ph: (805) 466-6939 Fax: (805) 466-6989

Patient Name: _____ Date of Birth: _____

Responsibility for Fees & Charges

In order to control the cost of billing we ask that the patient's portion be paid at the time services are rendered, unless other arrangements are made in advance. We would like to control billing costs rather than be forced to raise our fees. All professional services and materials are charged to the patient and all sales will be final unless the materials purchased are defective. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. The office does not bill secondary insurances. Accounts 90 days old are subject to collection fees. There will be a service charge of $25.00 on all returned checks. There will also be a charge of $25.00 for missed appointments without 24 hour notice.

_____ _____

Signature Date

Receipt of Notice of Privacy Practices & Consent Form

I understand that under the Health Insurance Profitability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received or have been offered the Notice of Privacy Practices from Optometric Care Associates.

[ ] I agree to have my medical information, regarding my appointments, glasses, and eye health discussed with those listed below:

_____ _____ _____ _____

Name Relationship Name Relationship

[ ] I authorize Optometric Care Associates to communicate and leave messages via telephone, text or email.

_____ _____

Signature Date

If signing as a personal representative of the patient, describe your relationship to the patient: _____