Family Eye Care & Vision Therapy

Patient consent to use and disclosure of Health Care Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand as part of treatment, payment or healthcare operations it may become necessary to disclose health information to another entity (i.e. referrals to other healthcare providers and insurance companies for payment). I understand this information serves as:

- A basis for planning my care and future treatment
- A means of communication among healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third party can verify that services billed were actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

Indicate what we may contact you about and ALL accepted methods of contact:

	yes	no	Home#	Work#	Cell#	Email	Mail
Appointment confirmation	☐	☐	☐	☐	☐	☐	-
Recall reminder	☐	☐	-	-	-	☐	☐
Order information	☐	☐	☐	☐	☐	☐	-

I give permission to share appointment, treatment, and payment information with the persons named below: Example: Immediate family members (parents, spouse, and children).
Name(s):_____

A copy of "Notice of Patient Privacy Practices" which provides a more complete description of information uses and disclosures of your health information is available to you, at your request.

I give permission for Family Eye Care & Vision Therapy to use the methods of communication indicated and I have been provided the opportunity to read and retain a copy of "Notice of Patient Privacy Practices".

Print name_____ Date_____

Signature_____
(parent/ guardian of minor)

Patient/Guardian consent for filing Medical/Vision Insurance and Private Pay responsibility.

Vision insurance covers routine eye exams, glasses or contact lenses. Medical insurance covers disease, problems or injury to the eye. Our office must adhere to the guidelines set forth by your insurance companies. Those guidelines determine which plan our office must bill for today's visit. The patient is responsible for all copays and deductibles required by each insurance plan. I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay and fails to do so.

Medicare and most medical plans do not pay for the refractive part of an eye exam. The refraction is what determines your need for glasses. The patient is responsible for this charge.

I request that payment of authorized Medicare benefits, or other insurance be made on my behalf to Family Eye Care & Vision Therapy, Inc. for any services provided and that I will turn over to Family Eye Care & Vision Therapy any insurance payment made directly to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents that information needed to determine the benefits payable for related services.

Private pay patients are responsible for payment at time of services for exam and material related charges.

Print name_____ Date_____

Signature (responsible party) _____