Acknowledgement of Receipt of Privacy Practices (HIPAA)

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have been informed of the Notice of Privacy Practices and have been offered a copy.

Patient Signature (guardian if under 18) _____ Date _____

PLEASE **PRINT Patient** Name _____

In order to protect your privacy, Scott Eye Care Ltd. asks you to list any person(s) that may request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

Name _____ Relationship _____

Name _____ Relationship _____

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)

•Vision care plans ONLY cover routine vision exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

2. Medical Insurance (such as BCBS and Medicare)

•Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

•If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
•We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.
I have read and agree with these policies.

Patient Signature (guardian if under 18) _____ Date _____

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and /or Medicare benefits and I authorize payment of these benefits directly to Scott Eye Care Ltd., on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature (guardian if under 18) _____ Date _____