ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Neuro-Vision Associates of North Texas and its affiliated organizations make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me that Neuro-Vision Associates of North Texas and its affiliated organizations Notice of Privacy Practice and agree to continue my care with that Neuro-Vision Associates of North Texas and its affiliated organizations under said terms.
- ☐ I was given to opportunity to read that Neuro-Vision Associates of North Texas and its affiliated organizations Notice of Privacy Practices and declined but wish to continue my care with that Neuro-Vision Associates of North Texas and its affiliated organizations under the terms of that Neuro-Vision Associates of North Texas and its affiliated organizations privacy policies.
- ☐ I have read or had explained to me Neuro-Vision Associates of North Texas and its affiliated organizations Notice of Privacy Practice and do not wish to continue my care with Neuro-Vision Associates of North Texas and its affiliated organizations under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

Neuro-Vision Associates of North Texas and Affiliated Organizations
Authorization of Use and Disclosure of Protected Health Information

Expiration Date Of Authorization: There is no expiration of this authorization. However, this authorization can be terminated at any time at the written request of the patient.

Right to Terminate or Revoke Authority: You may revoke this authorization by submitting a written revocation to Neuro-Vision Associates of North Texas and affiliated organizations. You should contact the Public Information Officer to terminate this authorization.

Potential for Re-Disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulation.

Authorization to Contact and/or Leave Notice: Neuro-Vision Associates of North Texas and its affiliated organizations contacts patients by email or phone to remind or inform of future appointments or other medical information. This authorization allows us to contact you either by email or by leaving a message, for such purposes. Please list the contact phone number and names of persons with whom we may discuss your protected health information:

Communication Preferences

Location	**Can we contact you here?**		**Can we leave a text/message?**	
Home Phone:_____	**Yes**	**No**	**Yes**	**No**
Work Phone:_____	**Yes**	**No**	**Yes**	**No**
Mobile Phone: _____	**Yes**	**No**	**Yes**	**No**
Email address:_____	**Yes**	**No**	**Yes**	**No**

Please list up to two people other than your insurance company or healthcare provider with whom we can talk to about your healthcare information:

_____

Name (print or type) Relationship Phone number Email

_____

Name (print or type) Relationship Phone number Email

Signature:

_____ _____

Signature of Patient Signature of Patient Representative

_____ _____

Name of Patient Name of Patient Representative

_____ _____

Date Date

Financial Responsibility Policy for
Charles Shidlofsky, O.D., P.A.
d/b/a Neuro-Vision Associates of North Texas

This document is provided to you so that you will understand both your responsibility as the patient, and our responsibility as the provider in regards to your insurance coverage.

We accept assignment to many insurance companies, which means, we accept a negotiated rate as a provider. As a courtesy to our patients, we do file the initial insurance claims for those companies for which we have agreed to accept assignment. All insurance information must be presented at the time of your examination. We cannot accept any changes to this information past the date of service. After that time, we can provide any information you need so that you can file the claim on your own for reimbursement.

Some health plans require that we inform you in advance that they may deny payment for "services not covered", "services not deemed by the health plan to be reasonable and customary or medically necessary", "services not covered for this type of provider", "diagnosis not appropriate for this type of procedure"and "procedure has been deemed to be experimental". Charles Shidlofsky, O.D., P.A. renders only services that, in their professional judgment, are necessary to provide quality health care for you.

In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement.

Agreement: I have been notified by Charles Shidlofsky, O.D., P.A. that payment may be denied for the reasons above, or that have been specifically requested by me, the patient.

If payment is denied, I agree to be personally and fully responsible for payment within ninety (90) days. Any balance deemed patient responsibility and which remains unpaid after 90 days of invoices will be subject to collections with finance charges. If your payment is assigned to third party collections you agree to reimburse us the fees for any collection agency, which may be based on a percentage at a maximum of 33% of the debt and all costs, and expenses, including reasonable attorney's fees, we incur in such collection effort.

Signature_____ **Date**_____

Your Health Plan Coverage

Charles Shidlofsky O.D., P.A. is committed to providing you with the best possible care and helping you to receive maximum benefits under your health plan. In order to achieve these goals, we need your assistance.

1. It is your responsibility to know if a referral is necessary for your visit.
2. Co-payments are due at the time of the visit. We are considered "Specialty Co-payments".
3. A valid, current insurance card must be presented at each office visit.
4. If the service is not a covered benefit, or if your health plans tells us you are not covered, **payment in full for all services rendered are due on date of service.** If your insurance subsequently makes payment, any over payments will be refunded to you.

Regarding Your Health Plan

1. Your insurance is a contract **between you, your employer and the insurance company.** We are not party to that contract. While we may have an agreement with many of the health plans to provide services, **any questions regarding coverage must be resolved by you with the insurance company.**
2. **Not all services are a covered benefit in all contracts.** Some health plans select certain services that they will not cover.

By signing below, I acknowledge that I have read this information and understand completely.

Signature_____ **Date**_____