Receipt of Notice of Privacy Policies & Consent Form

Cockrell Eyecare Center and The Laser Eyecare Center of Stillwater

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

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 health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our websites: www.cockrelleyecare.com or www.stillwaterlasik.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

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 the *Notice of Privacy Practices* from Cockrell Eyecare Center or The Laser Eyecare Center of Stillwater.

_____ _____

Signature Date

Persons authorized to receive personal information:

Name:_____Relationship:_____

Name:_____Relationship:_____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

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cec@cockrelleyecare.com

Office Policy

WE ARE IN NETWORK WITH THE FOLLOWING INSURANCE COMPANIES:

INSURANCE/COMPANY NAME	BENEFIT
AETNA	MEDICAL/ROUTINE MAY BE EYEMED
ARMSTRONG/BCBS	ROUTINE EYE EXAM/MEDICAL VISITS
BLUE CROSS BLUE SHIELD	ROUTINE* AND MEDICAL VISITS
CIGNA	MEDICAL VISITS-MAY BE VSP
COAST TO COAST-DISCOUNT PLAN	ROUTINE VISION ONLY
COMMUNITY CARE-Network participation must be verified	ANNUAL VISION EXAM AND MEDICAL VISITS
COVENTRY/MAIL HANDLERS	ROUTINE*MEDICAL POLICIES MUST BE VERIFIED FOR IN NETWORK ELIGIBILITY
CREC-UMR	ANNUAL ROUTINE VISION/MEDICAL VISITS
EYEMED	ROUTINE VISION ONLY
1St Health	ROUTINE* AND MEDICAL VISITS
HEALTHCHOICE	MEDICAL VISITS ONLY
MEDICAID/SOONERCARE	ROUTINE AND MEDICAL VISITS
MEDICARE	MEDICAL ONLY
MET LIFE VISION	ROUTINE ONLY
PREFERRED COMMUNITY CHOICE	ROUTINE* AND MEDICAL VISITS
STILLWATER MEDICAL CENTER/WEB-TPA	MEDICAL VISITS and may have VSP
TRICARE	ROUTINE VISION* AND MEDICAL VISITS-Tricare prime requires prior authorizations for medical visits
UNITED HEALTHCARE	ROUTINE * AND MEDICAL VISITS
VISION CARE DIRECT	ROUTINE VISION W/ PRE-AUTHORIZATION
VISION CARE PLAN	ROUTINE VISION W/ PRE-AUTHORIZATION
VSP-VISION SERVICE PLAN	ROUTINE VISION W/ PRE- AUTHORIZATION

ROUTINE VISION BENEFITS NOT ON ALL PLANS-WE WILL VERIFY IF ANY BENEFITS ARE AVAILABLE WITH YOUR GROUP.

WE WILL FILE ANY MEDICAL CLAIM FOR YOU IF YOUR PLAN ALLOWS US TO PROVIDE YOU WITH A MEDICAL SERVICE. (SOME PPO'S AND HMO'S WILL NOT COVER YOU IF YOU ARE OUT OF NETWORK-IT'S YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE AND YOUR NETWORK)

If you have insurance for vision care **or** for medical care, we need to know the name of your insurance company as well as any additional information necessary to file a claim. Many companies now require pre-approval or pre-authorization before eye care services are performed. ***If your insurance requires pre-authorization and it is not requested prior to your eye care, the insurance company will not pay the bill and you will be responsible for the fees.***

1. Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company.
2. Even though we will file your insurance claim, this office cannot accept responsibility for negotiating a settlement on a disputed claim. **You are ultimately responsible for the balance on your account should your insurance company deny your claim for any reason.**

ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the above information on this sheet and have provided the information requested if applicable on my insurance. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance or routine vision coverage. I request that payment of authorized medical or routine vision benefits be made to Cockrell EyeCare Center, Inc. on my behalf for any services furnished by Cockrell EyeCare Center, Inc. if applicable. I authorize Cockrell EyeCare Center, Inc. to release to the health plan indicated if applicable, any information needed to determine these benefits or benefits payable to related services.

Date **Signature** _____