TRIANGLE
FAMILY EYE CARE

TRIANGLE FAMILY EYE CARE HIPAA/INSURANCE POLICY

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Triangle Family Eye Care to release any of my medical health information necessary to process any insurance claims on my behalf.

I authorize Triangle Family Eye Care to release any of my medical health information to other medical health care practitioners to whom I may be referred to for further medical evaluation.

ASSIGNMENT OF BENEFITS

I authorize payments of insurance related medical or vision benefits to Triangle Family Eye Care.

OFFICE POLICY ON ALL INSURANCE

You must provide your insurance information at the time of your visit for Triangle Family Eye Care to file your claim. Otherwise, you will be required to file the claim yourself. We only accept assignment on insurance plans for which we are providers. All co-payments, coinsurance and deductible amounts are due at the time of service.

If your plan offers discounts on materials, all charges must be paid at the time of the order. If you find that you have insurance AFTER your visit, we are not able to adjust fees to reflect any difference in the payment schedule of your insurance plan.

Your signature is kept on file acknowledging our policy regarding insurance and authorizes us to file insurance claims on your behalf. Please understand that you are ultimately responsible for paying for all services and materials irrespective of insurance benefits.

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

Name: _____ Date: _____

Signature: _____