Agreement of Responsibility

WAIVER OF RESPONSIBILITY

I understand there are risks associated with using my own frame and that Valley Eye Associates is not responsible for any damage done during adjustments or insertion of new lenses.

FINANCIAL POLICY-SIGNATURE ON FILE FORM

We make every effort to keep down the cost of your medical care

- All fees are due the same day services are rendered or that the materials are ordered
- We accept the following forms of payment: Cash, Checks, Master Card, Visa, American Express, and Discover
- The patient who seeks care is responsible for the payment of all fees
- The person bringing the child into the office is responsible for the payment of all fees.
- Additional fees for administrative services apply. These fees may include, but are not limited to, fees for medical records as allowed by law, fees for non-covered services rendered and fees for the completion of forms you may request.
- If an appointment is cancelled with less than 24 hours' notice, a cancellation fee will be applied to the patient's account
- If an attorney's services are required or if it is necessary to resort to small claims court, the patient will be required to pay the attorney's fees and the costs of court in addition to paying the amount due or ordered by the court.

PATIENTS WITH THIRD PARTY PLANS

I authorize my third party plan to pay Valley Eye Associates directly. If this is not permitted by my policy then send the check made out to Valley Eye Associates at the following address:

Valley Eye Associates
219 Old Hook Road
Westwood, NJ07675

I authorize Valley Eye Associates to file complaints on my behalf if my third party carrier does not properly handle my claim. In order to ensure payment of my claim, I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in a treatment, both directly and indirectly.
- Obtain payment from third party payers.
- Conduct routine healthcare operations, such as quality assessments and physical certifications.

I have been informed by Valley Eye Associates and the Notice of Privacy Practices (see forms below) which contains a more detailed description of the uses and disclosures of my health information. I have been given the right to review and sign this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Valley Eye Associates restricts how my private information is used or disclosed to carry out treatment, payment, or health care options. I also understand that Valley Eye Associates is not required to agree to my request restrictions, but if Valley Eye Associates does agree then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, excluding the extent in which Valley Eye Associates has already taken action relying on this consent.

Patient's Name (OR Responsible Party)_____

Signature of Patient (OR Responsible Party) _____

Date _____