Haywood Family Eye Care, OD, PLLC

Patient Financial Responsibility

I agree that in return for services provided by Haywood Family Eye Care, OD, PLLC, I will pay my account at the time services are rendered. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Haywood Family Eye Care, OD, PLLC. I further understand and agree that failure to pay amounts owed in full at the time of services could result in additional charges and fees. I agree to pay for any and all charges for services rendered by Haywood Family Eye Care, OD, PLLC that are denied for payment by my insurance plan. I understand that if my insurance plan has not paid within 45 days from the date of service, I may be billed by Haywood Family Eye Care, OD, PLLC for the full amount of my services and materials. **Please keep in mind that your health insurance policy is an agreement between you and your insurance company - what insurance does not pay will become your responsibility.**

Assignment of Benefits

I understand that services rendered to me by Haywood Family Eye Care, OD, PLLC are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Haywood Family Eye Care, OD, PLLC and I understand I will be fully responsible for any outstanding balance on my account. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I also understand that should my insurance company send payment to me, I will forward the payment to Haywood Family Eye Care, OD, PLLC within 48 hours.

Signature on File For Insurance Billing Purposes

A. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Haywood Family Eye Care, OD, PLLC for services furnished me by Haywood Family Eye Care, OD, PLLC. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Haywood Family Eye Care, OD, PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

B. **OTHER INSURANCE:** I hereby authorize payment of my medical and surgical insurance benefits to Haywood Family Eye Care, OD, PLLC. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Haywood Family Eye Care, OD, PLLC. I authorize Haywood Family Eye Care, OD, PLLC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Release of Information

I authorize the release of information including the diagnosis, records, invoice and financial, examination rendered to me, and claims information. This information may be released to: (PLEASE WRITE NAME OF PERSON)

❑ Spouse _____ ❑ Child(ren) _____ ❑ Other _____

OR

❑ My health information is **NOT** to be released to **ANYONE.**

Acknowledgement of Notice of Privacy Practices

The law requires that Haywood Family Eye Care 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 Haywood Family Eye Care's Notice of Privacy Practices:

I AGREE to continue my care with Haywood Family Eye Care under said terms.

I have read and understand these policies.

X _____ _____

Patient signature (Parent, if patient is under 18) Date

Messages & Notifications

Please call:

❑ My home _____ ❑ My work _____ ❑ My cell number _____

May we leave a message?: ❑ Yes ❑ No Your e-mail address:_____

New Patients

How did you hear about our office? _____

If referred by another patient, whom may we thank for the referral? _____