PRIVACY PRACTICES ACKNOWLEDGEMENT

Our goal is to provide you with the best care available. In order to achieve our goal, we ask for your understanding and cooperation regarding the following payment/insurance policies:

1. We ask that payments be made at the time of your visit unless other arrangements have been made in advance.
2. If you are a member of an HMO plan, you need to have a VALID referral for each office visit. Please call our office in advance to make sure you have the necessary forms and authorization.
3. Our payment policy also requires that payments for refraction are expected at the time of service for all Medicare patients as well as for those patients whose insurance does not cover refraction.

Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to The Eye Site for any service rendered to me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable to related services.

Non-Medicare Patients:

I hereby authorize payment to The Eye Site of any services rendered to me. I authorize The Eye Site to release such medical or other information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided.

I accept and understand the above payment/billing policies as outlined above.

Signed (Patient, or Guardian)_____Date_____

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I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name: _____

Signature:_____Date_____