COMPLETE VISION CARE

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

The law requires that we make every effort to inform you of your rights related to your personal health information.

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 your services, and to conduct health care operations involving our office. The Notices of Privacy Practices (NPP) describes these uses and disclosures in detail. I acknowledge that I have received or refused the NPP.

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Patient or Legal Guardian's Signature Date

- I (do) ____ (do not) ____ authorize COMPLETE VISION CARE or their staff to leave a message with available persons at my phone number(s), on my answering machine(s) or with the emergency contact listed.
- I (do) ____ (do not) ____ authorize COMPLETE VISION CARE or their staff to leave a message at my place of employment.
- We may use your email for recalls, surveys and coupons or marketing purposes, if you wish to not receive these via email, please ask the receptionist for a separate opt out form to be completed.

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

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Patient or Legal Guardian's Signature Date

FINANCIAL & INSURANCE FILING POLICY

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *If your insurance company does not pay within 45 days, we will require you to pay the balance by cash, check, money order, Visa MasterCard, or Discover.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *I understand that failure to pick up any item that I have ordered for myself or my dependents without notifying the office to cancel the order within 24 hours of ordering will be payable in full and that any special order items are non-cancelable.*
- *We accept cash, checks, money orders, Visa, MasterCard, and Discover.*
- *Canceled or rescheduled appointments are subject to a fee if we do not receive 24 hours advance notice.*
- *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*
- *Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a one dollar ($1.00) billing fee will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in, COMPLETE VISION CARE, being unable to provided additional services. Except for emergencies or where there is prepayment for those additional services. In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.*

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I ___________________________________, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to COMPLETE VISION CARE I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to COMPLETE VISION CARE for any services furnished to me by COMPLETE VISION CARE I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges.

I have read & understood the information contained within this document, and I am signing voluntarily.

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Patient or Legal Guardian's Name (Print)

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Patient or Legal Guardian's Signature Date