HIPPA Acknowledgment & Authorization

I hereby authorize my insurance company or any other third party payer to pay directly to The Eye Sight Center / Neovision for all optical and / or medical charges submitted for services incurred by me. I understand that I will be responsible for any and all charges not paid by my insurance company or third party payer. I authorize The Eye Sight Center / Neovision to release information concerning my eye condition to my insurance company, employer, attorney or multiple health care providers who may be involved in the treatment directly or indirectly. I assign payment directly to the doctors at The Eye Sight Center / Neovision which may cover in whole or part of the vision services that I have received. The authorization shall be valid until I notify The Eye Sight Center / Neovision in writing of a cancellation. A photo copy of the authorization shall be as valid as the original copy.

I hereby acknowledge that I have read the HIPPA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide The Eye Sight Center / Neovision with my authorization and consent to use and disclose my protected vision/health care information for the purposes of treatment, payment, and health care operations as described in the HIPPA Privacy Policy.

Signature of patient, parent or guardian _____ Date _____

Relationship to patient _____

Insurance

In order to meet the needs of our patients, we have enrolled in various insurance programs. As you can imagine, keeping up with all of the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided and how often they can be provided. These rules can vary even in the same company with various programs being offered. At The Eye Sight Center / Neovision, providing the highest quality in eye care to our patients in an atmosphere of genuine caring is our primary concern. It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your particular insurance policy so if we work together, both doing our parts to familiarize ourselves with your specific policy, we can focus on what we do best – taking care of you.

I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. If these are disallowed, I understand that I am responsible for payment. I understand that I am also responsible for any balance that is not paid by my insurance company after 30 days.

Signature of patient, parent or guardian _____ Date _____

Relationship to patient _____