

Pt Name _____ Acct# _____



Billing, Privacy and Insurance Authorization

Please read and sign this form prior to your appointment.

Insurance

We participate in many insurance plans. If you are not insured by a plan we do business with or do not have an up-to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information we bill primary and secondary insurance. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please contact your insurance company with any questions you may have regarding your coverage.

Payment

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check and credit/debit cards.

Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is Refraction, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge your refraction fee separately from your exam. Optomap retinal scans are also non-covered and may not be billed to your insurance or Medicare. Payment for these services must be paid at the time of your visit.

Optical/Contacts

Eyewear orders must be paid in full at time of your order unless covered by vision insurance. Medical Eye Center Optical does not accept Medicare assignment on eyewear. If eligible, Medicare will reimburse you directly for covered eyewear.

Contact lens "fitting" is not included in a routine eye exam; it is a separate procedure with an additional charge. Many insurance companies do not pay the fitting charge. A 50% deposit of the contact lens and fitting fee total is required before ordering lenses unless covered by a contracted insurance plan. Payment arrangements may be made in advance for eyewear and contact lens orders.

Patient Acknowledgement and Authorization

I accept financial responsibility for all payments for services and products received. I authorize Medical Eye Center Inc., Medical Eye Center Optical, Inc. and Laser and Surgical Eye Center LLC to send copies of my records to other physicians as needed for continuity of care. I understand this is a group practice and other eye doctors may be involved in my care.

I authorize these organizations to bill my insurance for services provided, and to make available any information needed to process my claim. I assign all insurance and/or Medicare benefits to these organizations for services provided by them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as this original.

I acknowledge that I have received a copy of this organization's Notice of Privacy Practices (HIPAA).

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Summary of our Notice of Privacy Practices

Medical Eye Center, Inc. and Laser & Surgical Eye Center, LLC, (our surgery center).

We value the trust of our patients.

We care about the security of the information you provide us.

HIPAA Law (**H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996) requires that we hand you a copy of our Notice of Privacy Practices. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know for the reason of treatment, payment, and/or health care operations. If we were to disclose your information for any other reason, we would first need your written approval.

Amendment to the Policy of Privacy Practices

From Page 3, Section: Family and Friends

Our policy has changed to no longer require verbal approval from the patient to share private health information with family or others when we feel it's in the patient's best interest to share appointment or health care information. This means we will answer family questions, and confirm appointment information if the inquiry is made on behalf of a patient. If you do not agree with our policy, please indicate your wishes regarding the handling of your health information on the **Acknowledgement and Consent Form** after having a chance to review our Policy of Privacy Practices.

Signature: _____ Date: _____