HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

My Authorization

I authorize Cates Family Eye Care to disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

The above party may disclose this health information to the following recipient:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient: _____ Date _____

<u>If the patient is a minor or unable to sign, please complete the following</u>:

☐ - Patient is a minor

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

CATES FAMILY EYE CARE FINANCIAL AGREEMENT

The following contains important information concerning your financial responsibilities and your treatment at Cates Family Eye Care (CFEC). Please read it carefully.

1. FINANCIAL AGREEMENT: Payment for services is due in full at the time services are rendered. A 50% down payment must be made for any glasses at the time they are ordered, with the remaining balance due at the time of pick-up. Contact lenses must be paid in full at the time of order.

Because services are based on medical necessity it is impossible for CFEC to provide a total cost prior to evaluation. CFEC will bill insurance as a courtesy, but this is not a guarantee that insurance will pay for services rendered or materials provided. It is the patient's responsibility to know insurance benefits and coverage. If you do not have your insurance cards at the time of your visit, you will be required to pay for all services and materials at the time of service and file the insurance claim yourself. Also, if you find out after services/materials are rendered that you have a vision plan, it is your responsibility to file a claim for services already rendered and materials already provided. The patient is responsible for all copays, deductibles and services or materials not covered by insurance. In the event it becomes necessary for CFEC to enlist the services of a collection agency and/or legal assistance, the patient is responsible for any collection expenses and reasonable fees.

2. NON-COVERED SERVICES: CFEC's agreements with health insurance plans (i.e. HOMs PPOs) relates only to items and services which are "covered" by the insurance plan. The patient accepts full financial responsibility for all items or services, which are determined by insurance not to be covered, including the refraction fee.

3. MEDICARE: Payment of authorized Medicare benefits may be made on the patient's behalf to CFEC for services furnished to the patient by CFEC. Any holder of medical information about the patient is authorized to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. The patient's Financial Agreement signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other heath insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, the patient's signature authorizes releasing the information to the insurer or agency shown. CFEC accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

4. MEDIGAP: Payment of authorized Medigap benefits will be made to CFEC on the patient's behalf for any services furnished to the patient by CFEC. Medical information about the patient may be released to the Centers for Medicare and Medicaid Services and its agent to determine payable benefits for relates services.

5. HIPPA PRIVACY POLICY: CFEC is authorized to use and disclose protected health information to all authorized individuals. This authorization for release of information covers the health care services provided from all past, present and future periods. By signing below, I authorize the release of my complete health record including the diagnosis records, examination rendered to me and claim information.

Please sign below as acknowledgement of HIPAA and Financial Responsibility stated above:

Signature_____ Date _____