PATIENT FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICE

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICIES AND CONSENT TO DISCLOSE HEALTH INFORMATION

By my signature, I hereby acknowledge that I have received a copy of the Notice of Privacy Policies for the Practice. I hereby consent to the Practice's disclosure of my medical information for treatment, billing, and health care operations (collectively TBO). I understand that my medical record contains, or may contain in the future, information classified as confidential. By my signature, I specifically consent to the disclosure of such information for TBO purposes and in compliance with HIPAA regulations.
Initial__________

FINANCIAL RESPONSIBILITY

By my signature, I hereby assign to Putnoi Eye Care the right to receive payment of benefits for services rendered to me, by Putnoi Eye Care, from my insurance carrier and/or my Medigap coverage. I understand I am required to present my insurance information and valid photo identification at the time of check-in. I am responsible for any co-payment or deductible at each visit, in accordance with my insurance policy**.** I understand that I am financially responsible to the Practice for services I receive which are not covered by my health insurance. **I also understand that any testing done during my visit may be processed to my deductible or coinsurance, in accordance with my insurance policy.**
Initial__________

LACK OF VALID REFERRAL

By my signature, I understand that my insurance company may require that I obtain a valid referral/authorization from my primary care physician for the services provided today. If a valid referral is not on file at the time of my visit, my insurance company may deny payment. **This document serves as notification that in the event of insurance denial(s) of the claims filed on my behalf, I will be responsible for any/all balances due.** Initial__________

PAYMENT FOR COPAYS AND NON-COVERED SERVICES

By my signature, I understand that any copay(s) or payments for services not covered by insurance are due on the date of service. Non-covered Services (such as those noted below) must be paid on the date of service: Contact lens services, Refractions for Medicare patients, Cosmetic products, Specialty lenses or supplemental services for cataract surgeries, surgeries and/or procedures that require prior authorization and are not authorized. Initial__________

INSURANCE AUDIT OR REVIEW

By my signature, I understand that all services may be subject to audit and/or review by my insurance company, even after services have been authorized or approved, and a claim has been submitted, and/or paid. I understand I may be responsible for payment of such services. Initial__________

MISSED APPOINTMENTS

By my signature, I understand that if I need to cancel or reschedule an appointment and do not provide 24 hour notice prior to the scheduled appointment, I will be responsible for a $50 missed appointment fee. Initial_________

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PRINT NAME

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SIGNATURE DATE