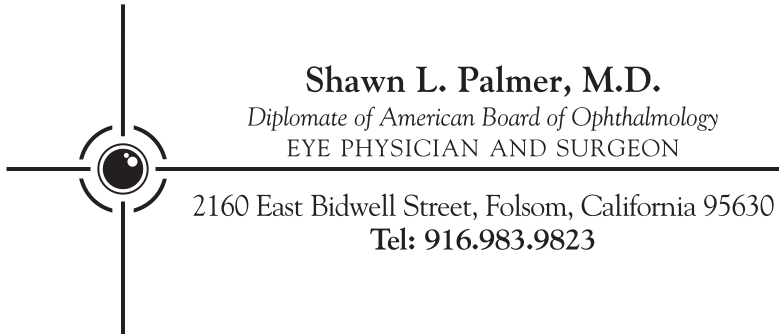

Office Policies and HIPAA Regulations Acknowledgment

I hereby authorize my physician to release any information acquired in the course of my treatment necessary to process insurance claims and ***comply*** with the insurance company's evaluation and utilization review process. ***I understand that this office will not bill any insurance in any manner that will violate its contract with any company.***

I hereby agree to present the full co-payment amount at registration on the day of my appointment. I understand that failure to submit the co-payment on the day of the appointment will result in an assessment of $10.00. I further agree that in the event my medical insurance does not cover the entire cost of my examination this office cannot bill a vision carrier to cover the extra amounts. Insurance contracts will not allow us to do this.

I have read and understand that my physician abides by the policies set forth in the HIPAA guidelines, which are available to me in the physician's office.

I hereby agree to and will adhere to the following policies:

A. All appointments missed or cancelled with less than 24 hours previous notice will be assessed a minimum of $25.00.
B. All returned checks will be assessed a $25.00 handling fee.
C. Any insurance or disability forms which need to be filled out by the provider are assessed $15.00 for the first page and $10.00 each additional page. This fee is due at the completion of the forms. This office will not bill for this service.
D. Copying of medical records will be assessed a fee due at the time of copying. $10.00 for the first 10 pages, and $0.25 per page thereafter. Alternatively, I may have a copy service copy my records.

I hereby agree that failure to adhere to the above office policies may result in dismissal from this medical practice.

_______________________________________ _______________________
Signature of Patient or Guardian Date

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I hereby authorize any medical information to be released to my husband/wife ______________________

or ___________________________ who is my ___________________________________.

_______________________________________ _______________________
Signature Date