SOUTHERN EYE GROUP

Biloxi • Fairhope • Foley • Gulf Breeze • Mobile • Pensacola • Saraland • Spanish Fort • South Foley

Salmedina Alic, OD | Donna Corder, MD | Ayesha Kidd, OD | Paul McDaniel, DO | Hong Nguyen, OD | Courtney Ray, MD

Ray Rojas, MD | Gayla Rowland, MD | Dan Wilder, OD | Taylor Wolkart, OD | Peter Zloty, MD

Privacy and Billing Consent Form

Patient Name: _____

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy to your health care information.

Consent Related to Privacy Notice

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by the agreement.

Consent for Care

I, with my signature, authorize Southern Eye Group and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, and maintenance. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- As a courtesy to our patients, we will verify insurance for eligibility benefits prior to the first appointment, as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for services to be performed. Any services that are not covered by your insurance are your financial responsibility.
- New Insurance, as well as changes in your insurance, must be provided to our office prior to your appointment and is your responsibility to provide. Any change to your personal information, such as address change and telephone number are also your responsibility to provide at the time of service to prevent any insurance denial.
- I understand that I am responsible for all co-payments, amount applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. This payment will be due at the time of service. Additionally, any past due balance must be paid, or a payment plan must be established before being evaluated.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Southern Eye Group is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving services. For example, not all health plans include screening as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.
- Any over-payments or requested refunds will be reviewed by management and refunded to the appropriate party. Patient refunds will not be processed until all active and past due accounts and insurance claims have been paid in full. Any balances of $25 or less will remain on the patient's account for one hundred twenty (120) days and if not used will be adjusted off.
- Southern Eye Group will assess a fee of $30 for all returned checks due to "non-sufficient funds". The patient will be responsible for this fee plus the amount of the patient balance. Southern Eye Group has the right to refuse checks by this party in the future if checks are returned due to "non-sufficient funds".
- Prompt payment of patient balances is expected per the terms of this agreement. When non-payment of services occurs, we are contracted with an outside collection agency and will use their services when deemed necessary.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care. I have read and understand the Consent and Financial Policy and agree to accept full responsibly as described above.

_____ _____

Signature of Patient (or Responsible Party) **Date**