SOUTHERN EYE GROUP

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.

- **VERIFYING INSURANCE:** 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 work to be performed. Any amount on your treatment plan that is not covered by your insurance is your financial responsibility.
- **INSURANCE INFORMATION:** New insurance, as well as changes in insurance, must be provided to our office prior to your appointment. Accepting assignment of benefits from your insurance company is the equivalent of extending your credit; therefore, we must have your Social Security Number on file. If you choose not to provide us with your Social Security Number, you will be responsible for payment in full. 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.
- **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail, and your balance is overdue, your account will be sent to a collection agency.
- **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of college student's full-time status and proof of continued enrollment in any insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
- **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following a previous visit, you will be expected to pay that amount or a payment plan must be established before being evaluated. If payment is made directly to you for services billed by Bay Eyes, you agree to promptly remit payment to Southern Eye Group (Bay Eyes Cataract and Laser). 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.
- **PAYMENT PLANS:** In addition to cash, checks, Visa, MasterCard, AMEX, Discover, we offer several payment plans – please see staff for details.
- **REFUNDS:** Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full. Any balances of $25 or less will remain on account for one hundred twenty (120) days, and if not used will be adjusted off the account.
- **RETURNED CHECKS:** There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within ten (10) days of notification by money order, cash, or credit card. Once a check is returned, this office will no longer accept a personal check for payment.

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)