AIO
THE EYE SURGEONS
VISIONARY EYE CARE℠

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:
❑ Cell Phone Confirmation ❑ Text Message to my Cell Phone
❑ Home Phone Confirmation ❑ Email Confirmation
❑ Work Phone Confirmation ❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:
❑ Cell Phone Confirmation ❑ Text Message to my Cell Phone
❑ Home Phone Confirmation ❑ Email Confirmation
❑ Work Phone Confirmation ❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:
❑ Phone Message ❑ **Any of the Above**
❑ Text Message ❑ **None of the above** (opt out)
❑ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:
❑ It was emergency treatment ❑ The patient was unable to sign because _____
❑ I could not communicate with the patient ❑ Other (please describe) _____
❑ The patient refused to sign

_____
Signature of Privacy Officer

PLEASE TURN OVER

THE EYE SURGEONS

VISIONARY EYE CARE℠

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Social Sec. #: XXX-XX- _____

Beneficiary Name (Print) _____ Medicare Number _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Associates in Ophthalmology for services furnished by Associates in Ophthalmology. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Associates in Ophthalmology accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. MEDIGAP: I understand that if a MediGap policy or health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Associates in Ophthalmology, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Associates in Ophthalmology may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation (1) which is or may be liable or under contract to Associates in Ophthalmology for reimbursement for services rendered, and (2) any health care provider for continued patient care. Associates in Ophthalmology may also disclose on an anonymous basis any information concerning my case, which is necessary and or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Associates in Ophthalmology maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Associates in Ophthalmology has no contract expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all the services rendered to me by Associates in Ophthalmology if he/she belongs to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Associates in Ophthalmology's contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care plan not to be covered.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Associates in Ophthalmology I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Associates in Ophthalmology. I understand and agree that if my account is delinquent, I may be charged a late fee. Any benefits of any type under any policy of insurance insuring the patient, or any party liable to the patient, are hereby assigned to Associates in Ophthalmology. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Associates in Ophthalmology. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the patient's bill.*

*X*_____ *X*_____

Beneficiary Signature of Authorized Party *Date*