Vision Associates of Hackettstown
915 Rt. 517, Unit B16
Hackettstown, NJ 07840
Phone: 908-852-3900 Fax: 908-852-3903

HIPAA

Authorization, Consent of Professional Services and Release of Information:
All professional services rendered are charges to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of coverage. All services provided to you as a patient of Vision Associates of Hackettstown are payable at the time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children." I hereby authorize Vision Associates of Hackettstown to furnish insurance companies or their representatives information concerning my (my dependent's) illness and treatments and hereby assign to Vision Associates of Hackettstown all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical exam, x-ray studies, laboratory procedures, medical care or any clinical services that he/she deems necessary in my case, and I further authorize him/her to disclose all or part of my (patient) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part if the clinic charge, including but not limited to hospital or medical services company, insurance company, worker's compensation carriers, welfare funds, or the patient's employer.

Patient Payment Information Consent:
I understand that Vision Associates of Hackettstown may need to disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services and for the purposes of practice. I consent to the use of my information for the purpose of treatment, payment and health care operations.

I understand that I have the right to review Vision Associates of Hackettstown if the law requires Vision Associates of Hackettstown to report some aspect of my health protected information to a government agency (for example, suspected abuse, communicable disease and potential bodily harm to myself or others.)

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment operations, Vision Associates of Hackettstown may refuse to undertake my care.

I, the undersigned hereby consent to the following treatment: Administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, performance of other medically necessary laboratory tests that may be considered medically necessary or advisable based on the judgment if continuing in mature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that Vision Associates of Hackettstown may include consent at satellite offices under common ownership.

Medicare Patients:
I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign benefits payable to Vision Associates of Hackettstown.

HIPAA Acknowledgement:
I have received and read Vision Associates of Hackettstown notice of privacy practices.

In my absence or for the benefit of gaining medical advice on my behalf, I authorize the following person to gain patient health information for or with me:

_____

(Please list authorized representative(s) or mark N/A)

I certify that I have read carefully and fully understand the above statements and consent fully and voluntarily to its content. Also that all information provided above is true and correct to my knowledge.

Signature: _____ ***Date*:** _____