FINANCIAL & INSURANCE POLICY

Dr. Kevin Hirano Optometry
3185 Old Conejo Road
Newbury Park, CA 91320
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Fax: 805-499-8314
kevin_hirano@yahoo.com

1. Payment for services (including co-payments/co-insurance/deductible) is <u>due at time of service.</u>
2. Verification of benefits by your insurance company and/or our office is not an absolute guarantee of payment. If your insurance denies payment for any service, we promise to notify you in a timely manner. However, full payment is due within 30 days of notification.
3. Not all services and products are necessarily covered by insurance. Furthermore, those that are covered may be dependent on your type of insurance, level of coverage, deductible met, and previously exhausted benefits.
4. The parent who schedules/accompanies a minor to our office for an exam is responsible for payment. Our office cannot be involved in divorce settlements and/or custody disputes.
5. A returned check for non-sufficient funds will be assessed a $30.00 returned check fee. The responsible party is liable for the unpaid balance plus the returned check fee.

I hereby acknowledge that I have thoroughly read, understand, and agree to the terms of this policy regarding insurance coverage and fee payment.

Patient's Signature ____ Date_______________
(or) Signature of Patient's Representative _________________________ Date_______________
Relationship to Patient____

HIPAA PRIVACY PRACTICES CONSENT

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected information about you to carry out treatment, payment, and the health care operations of our office. You may revoke this consent at any time by notifying our office in writing, except to the extent that our office has already taken action. You have the right to request our office to restrict the manner in which your protected health information is used or disclosed. Our office is not required to agree to such requested restrictions, however we will do our best to comply with any such requests.

I hereby consent to the use and disclosure of my protected health information by Dr. Kevin Hirano Optometry, its workforce, and its business associates for purposes of treatment, payment and health care operations. I am aware I can request a copy of Dr. Kevin Hirano Optometry's HIPAA Complaint "Notice of Privacy Practices" and it will be provided.

Patient's Signature ____ Date_______________
(or) Signature of Patient's Representative _________________________ Date_______________
Relationship to Patient____