Radiant Eyes - Payment and Billing Terms & HIPAA Acknowledgement

Patient Name: Date of Birth:

At Radiant Eyes, we are committed to providing you with clear information regarding your payment and billing responsibilities. Please **review the following terms carefully and sign at the bottom to indicate your understanding and agreement.**

1. Insurance Verification

Radiant Eyes will make every effort to verify your insurance benefits prior to your appointment. However, it is important to note that this verification does not guarantee coverage or payment by your insurance provider. Final determination of benefits and coverage is made by your insurance company after the claim is submitted.

2. Consent to Bill Insurance

By signing below, you authorize Radiant Eyes to bill your insurance provider on your behalf and to submit claims for services rendered. You also authorize the release of any necessary medical information required to process these claims.

3. Patient Responsibility for Payment

If your insurance provider denies a claim or provides less coverage than anticipated, you will be responsible for the remaining balance. This may include, but is not limited to, any deductibles, copays, coinsurance, or non-covered services

4. Payment of Exam Fees and Copays

All exam fees, copays, and any known out-of-pocket expenses must be *paid in full* on the date of service. We accept various forms of payment including cash, credit/ debit cards, and checks.

5. Non-Refundable Services

Please note that all services provided by Radiant Eyes are non-refundable. Once services are rendered, they cannot be returned or refunded.

6. HIPAA Acknowledgment

I acknowledge that! have been offered a copy of the Notice of Privacy Practices (NPP) for Radiant Eyes, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand my rights regarding the privacy and protection of my health information.

I consent to the use and disclosure of my protected health information (PHI) for purposes of planning, coordinating, and managing my treatment, including communication with other healthcare providers involved in my care. I also understand that my PHI may be used to obtain payment from third-party payers and for routine healthcare operations, such as quality assessments and provider certifications.

If the patient is a minor, I acknowledge that state and federal laws may grant the minor certain privacy rights for specific healthcare services. I agree to provide any required authorizations for the release of the minor's records as needed.

By signing below, you acknowledge that you have read and understand the payment and billing terms outlined above. You agree to the terms and accept financial responsibility for any balances not covered by your insurance provider.

Patient or Guardian Signature:

Relationship to Patient:

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.