

Patient Name: _____ DOB: _____ Today's Date: _____

HIPAA Consent to Use and Disclose Health Information

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. If you would like a complete copy of our office's HIPAA policy, please ask our front desk staff and a copy will be issued to you. A complete copy can also be accessed on our website. By signing below you acknowledge that you understand that the HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment and other healthcare operations. I understand that I have the right to revoke this consent in writing at any time. However, such a revocation will not be retroactive.

X _____
Signature of Patient or Authorized Representative

Date

Print Name of Patient or Authorized Representative

Staff Witness Signature

How can our staff contact you (appointment reminders, etc.)?

| | | |
|--------------|-----|----|
| Phone | Yes | No |
| Text Message | Yes | No |
| Email | Yes | No |

May we leave a message on your answering machine or on your voicemail? Yes No

Are there any family members that you'd like for us to be able to discuss your medical condition with? If so, please list:

| | | | |
|---------------|-----------------------|---------------|-----------------------|
| _____ Name | _____ Relationship | _____ Name | _____ Relationship |
|---------------|-----------------------|---------------|-----------------------|

PATIENT FINANCIAL RESPONSIBILITY

- I understand that I am responsible for my health insurance copay, deductible, co-insurance and non-covered services.
- Copayments and payments for non-covered services are due at the time of service.
- In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
- I understand that Somerset Vision Center does not participate with commercial vision insurance plans. In the event that a patient has one of these plans (EyeMed, Blue View Vision, VSP, etc.), they may pay out of pocket for their services and/or materials and may file reimbursement paperwork. We will provide itemized receipts for this. We cannot, however, guarantee reimbursement as we do not have a contract with these insurers.
- I understand that as a courtesy, Somerset Vision Center will bill my major medical insurance if a medical diagnosis is found during the course of my exam. In the event that my insurance company puts any portion of my bill to my responsibility, I will receive a bill and agree to pay in a timely manner (within 90 days).
- Any accounts with outstanding balances over 90 days old are considered Past Due and will be sent to collections. **There will be a collections fee of 30-40% added to the original balance due. You will be responsible for paying this new total before any additional services will be provided.**

Signature of Patient or Authorized Representative

Date