EST. 2010
The SPECTACLE Shoppe
PROFESSIONAL EYE EXAMS
EXCEPTIONAL EYEWEAR

Print Form

PATIENT ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge that you have **received a copy** of the Notice of Privacy Practices of Amanda Stebbins O.D., P.A.

Patient or legally authorized individual signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

CONSENT OF DISCLOSURE

FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

During the course of providing service to you, we create, receive, and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to safeguard your confidentiality. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations, that includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but also disclosures of your health information, as may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but is not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies, including optical personnel will have access to your health information.
- The payment of medical insurance benefits to Amanda Stebbins O.D., P.A. or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

By signing below, you acknowledge that you have read and understand the above information and voluntarily consent to the statements herein.

Patient or legally authorized individual signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

INSURANCE INFORMATION

VISION CARE INSURANCE

INSURANCE COMPANY NAME: _____
PRIMARY MEMBER: _____
MEMBER ID/SSN: _____
RELATIONSHIP TO MEMBER: _____
INSURED'S EMPLOYER: _____

MEDICAL INSURANCE

INSURANCE COMPANY NAME: _____
PRIMARY MEMBER: _____
MEMBER ID/SSN: _____
RELATIONSHIP TO MEMBER: _____
INSURED'S EMPLOYER: _____

INSURANCE IDENTIFICATION

Insurance identification and a picture ID is required for all patients.

- Your insurance identification card and picture ID will be photocopied for identification purposes, before the examination.
- We cannot honor third party insurance benefits without your proper identification.
- Prior authorization of insurance benefits from your insurance company is required before service is provided.
- Your insurance claim will not be processed without verification of eligibility, by our office, before your exam.
- If we cannot verify eligibility of benefits at the time of the exam, you will be responsible for the professional fees and obligated to pay at the time of service.

OUR FINANCIAL POLICY

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of reimbursing the patient for professional fees paid to the doctor and is not a substitute for your responsibility of payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance policy benefits and obligations. This includes your financial obligations for services provided, by the participating physician, and to obtain prior authorization when necessary.
- Health care regulations require the collection of all co-payments, deductibles, balances and non-covered professional fees at the time of service. It is you responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.
- If your insurance company does not pay for professional services within a reasonable time period, we have the right to bill you for the balance of your account.
- All examination fees and co-payments are collected at the time you received services. Insurance co-payments are collected at every visit.
- Some insurance companies only pay a portion of the professional fees (fixed allowances or percentages). Depending on your plan, you may be required to pay any outstanding balance on your account.
- Certain procedures, such as contact lens fittings, are elective and are not covered by insurance benefits. You will be responsible for all professional fees for any non-covered service, such as contact lens fitting fees.
- Professional examination fees are collected separate from the purchase of any eyewear.
- Discounts and promotional coupons are not accepted in conjunction with any other discount, coupon, insurance benefit or third party program.
- You must provide discount verification and promotional coupons at the time of service. Refunds, credits and account adjustments will not be provided at a later date.
- A $ 25.00 Administrative fee is charged on all returned checks.

By signing below, I acknowledge that I have read and understand the financial policy of Amanda Stebbins O.D., P.A. I accept financial responsibility for the professional services and understand that I will be responsible for any unpaid balance, on my account, in the event my third party insurance plan does not fulfill their contractual obligations.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)