

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Eyesight Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eyesight Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Eyesight Associates' Privacy Officer at P.O. Box 6479, Warner Robins, Georgia 31095. With this consent, Eyesight Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Eyesight Associates may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent, Eyesight Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Eyesight Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Eyesight Associates' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Eyesight Associates may decline to provide treatment to me.

Signature of patient or Legal Guardian

Patient's Name

Date

Eyesight's Associates Financial Policy

1. Proof of Insurance: Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk when the cause for treatment should be billed to a vision plan, liability insurance or worker's compensation instead of your regular primary insurance. Although we file and participate with many insurance companies, annual vision exams are not covered by most companies. Before the day of your appointment you should call your insurance company to verify that the provider you are scheduled to see and the services you are having are covered by them.

2. When Payment is Due: Payment is due at time of service. We accept cash, personal checks, and credit cards. All deductibles, co-pays and non-covered services are due at time of service (unless payment arrangements have been made in advance). If you have Medicare but Medicare may deem the treatment as "medically unnecessary" according to the HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and the fee for service is due at the check out counter. All Medicare patients will be required to pay the 20% co-pay based upon the current Medicare Fee Schedule at the check out counter unless proof of a secondary policy is evident. There is a \$20 fee for giving a glasses prescription to a Medicare patient. Glasses prescriptions are not considered "medically necessary" so you will be expected to pay this fee at check out. Pre-determined co-pays are due when you check-in for your appointment. If your co-pay is based on a percent (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay.

3. Our Responsibility to Report Non Compliance: It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co-pays and deductibles at time of service or who repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employer for further clarification of your benefits and obligations.

4. Financial Assistance: Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Financial Counselor. You will need to provide a copy of last year's tax returns and current paycheck stubs to be considered for assistance with our office.

5. Billing, Payments and Over Payments: If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in address, phone, or employment. All balances are due in full within 30 days of the billing date. If you cannot pay the balance in full within 30 days, please contact our office to see if

you qualify for any special payment arrangement options.

6. Past Due and Delinquent Accounts: Failure to meet your financial obligations may result in reporting you to the Collection Bureau of Houston County. Furthermore, you may be terminated as a patient from this facility. All attorney fees, court costs, and other expense related to collecting your account will be added to your outstanding balance. If we file your insurance and they have not paid within 45 days, the balance will automatically be transferred to your responsibility.

Patient Signature

Date

Eyesight Associates - A Division of Gayton Health Centre

Patient Information

Legal First Name Middle Last _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ (Circle One) Male/Female (Circle One) Single/Married/Widowed/Separated/Divorced

Date of Birth _____ Age _____ SS# _____

Patient Employed By _____ Work Phone _____

Are you retired? Yes/No Date Retired _____

How did you learn about our office? _____

Name of Doctor who referred you _____ City _____

Phone _____

Whom to notify in case of emergency? _____ Home Phone _____

Work Phone _____

SPOUSE INFORMATION

Name _____ Employer _____

Date of Birth _____ Work Phone _____

SS# _____ Retired? Yes/No Date Retired _____

MUST COMPLETE IF UNDER 18 OR USING GUARDIAN'S INSURANCE
FATHER MOTHER

Name _____ Name _____

Date of Birth _____ Date of Birth _____

SS# _____ SS# _____

Employer _____ Employer _____

Work Phone _____ Work Phone _____

AUTHORIZATIONS

Please present insurance cards to the receptionist.

I hereby authorize and request the medical treatment necessary for the care of the above named patient.

I authorize EYESIGHT ASSOCIATES to use and disclose protected health information about above named patient to carry out treatment, payment and healthcare operations. I understand that this may include the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by EYESIGHT ASSOCIATES. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further authorize and request that insurance payments be made directly to EYESIGHT ASSOCIATES should they select to receive such payment.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

Date

Patient/Parent or Guardian Signature

