Acknowledgment of Notice of Privacy Practices

Betts and Biddle Eye Care PA

Print Name____

The law requires that Betts and Biddle Eye Care PA make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Betts and Biddle Eye Care PA's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Betts and Biddle Eye Care PA to release my personal health information to the following individuals:

______________________________ ______________________________

I agree to the use of telemedicine when my doctor deems it appropriate. ___Yes ___No

My insurance plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my insurance plan

___ I do not authorize release of medical information to my insurance plan

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

___ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.

___ I do not authorize the use of standard email to communicate with me.

Email Address____

(We will not share your email address.)

I want to be alerted via text message for notifications. ___Yes ___No

Cell phone number____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

______________________________________ ____________________

Patient Signature Date

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 legal authority to make medical decisions for the minor.

______________________________________ ____________________

Representative Signature Relationship to Patient

Betts & Biddle EYE CARE

Dedicated to excellence in eye care

FINANCIAL RESPONSIBILITY

To our patients with Medical and/or Vision Benefits:

We will be happy to file your insurance claim form or take assignment on your medical/vision benefits for the plans with which we are contracted and of which you state you are a member.

We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Please note:

If your plan requires a referral, it is your responsibility to obtain that referral before your appointment. Betts and Biddle Eye Care is not financially responsible for insurance denials if you do not obtain a necessary referral.

Many insurance companies do not pay for the refraction (the process by which the Doctor determines your eyeglass prescription). As a courtesy, we will attempt to bill this service for you; however, you will be responsible for the $30 refraction fee if your insurance does not cover it. Note also that Medicare does not cover the refraction, and the $30 fee will be collected at check-out.

I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I also request payment of benefits either to myself or the party who accepts assignment for any insurance filed on my behalf.

Print name ____

Patient signature ____

Date ______________________

I authorize the release of information to the following family member(s) or representative(s):

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