VALLEY EYE
Clinic & Optical

Patient Name: _____ Date: _____

RELEASE OF INFORMATION

Privacy / Confidentiality of Patient Records

With the exception of any information necessary to file your insurance, do you wish to have Valley Eye Clinic release any eye examination information to another clinic without your written or stated permission?

___ Yes, release the information in my records

___ No, please keep the information confidential and do NOT release it without my written or stated permission.

ASSIGNMENT OF BENEFITS

The Patient/Guarantor assigns all the insurance benefits and/or Medicare benefits directly to Valley Eye Clinic. The Patient/Guarantor authorizes the release of all necessary information to file and complete the insurance claim(s).

FINANCIAL POLICY

- I understand that I am responsible for payment of services rendered and any materials provided, including any co-payment and deductibles not covered by my insurance.
- Balances older than 30 days may be subject to additional collection fees, service charge fees, late fees, and/or interest charges of 2% per month; an annual percentage rate of **24%**. Returned checks will carry an additional **$25 charge** to the patient's account balance. Should our office find it necessary to place your account with an attorney for collection, all charges incurred in this process will be your responsibility.
- Referrals/Disputes: If a referral from your primary care clinic is required, and you choose to be seen without the necessary referral, you agree to be responsible for the charges incurred if your insurance company refuses to pay for your visit with us.
- If, for any reason, you dispute the payments made by your insurance company, it is your responsibility to contact the insurance company.
- All professional charges are ultimately the responsibility of the patient. We file insurance as a courtesy, and we try to estimate the correct patient responsibility of charges, but any denied claims, co-insurance payments, deductibles, etc. are ultimately determined by your insurance plan and you will be responsible for any unpaid amounts as determined by your insurance contract.

Signing this document signifies that you understand that you can view and/or request a copy of the clinic's *Notice of Privacy Practices* located at the reception counter.

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* we have available describes these uses and disclosures in detail.

By signing below, I authorize Valley Eye Clinic & Optical to contact me via postcard, letter, phone/voicemail. or e-mail regarding future appointments, eyewear orders, product offerings, or treatment information.

I acknowledge that I have reviewed and accept the *Notice of Privacy Practices* from Valley Eye Clinic.

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Patient's Signature (Guarantor/Guardian, if patient is a minor) Date