EYE CAPITOL

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The full Notices of Privacy Practices of Eye Capitol, P.A. is available by request from our check-in desk, and is also available online at www.eyecapitol.com.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood the Notice of Privacy Practices of Eye Capitol, P.A., which contain a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME (please print) _____

SIGNATURE _____ **DATE** _____

FINANCIAL AGREEMENT

Signing this section IS REQUIRED of all patients before services or treatment s are performed

I understand that payment for services is due in full at the time services are rendered.

If ordering glasses or contact lenses, a 50% down payment must be made at the time they are ordered, with the remaining balance due at the time of pickup.

For patients using insurance:

I request that payment from my third-party insurer be made to Eye Capitol for any services or products furnished to me by this provider.

I authorize Eye Capitol to release any personal or medical information to any medical insurance, vision plan company, or its agents that is necessary for determining my benefits or collecting payment for services rendered.

I understand that I am responsible for any copays, deductibles, and co-insurance amounts after services have been rendered today. or materials not covered by my insurance. It is ultimately my responsibility to know my insurance benefits and coverage.

I understand that Eye Capitol will act as my agent in filing my insurance. However, if payment is not received after a reasonable attempt at collecting from my insurance carrier, then I am ultimately responsible for any charges not covered by my insurance company.

I understand that vision plans only provide coverage for routine eye examinations and discounts on glasses and contacts. I also understand that vision plans do not cover for any medical eye problems that I am having.

I understand that my medical insurance will be billed today if I am having any medical eye problem as determined by the doctor, and that I am responsible for any and all deductibles, copayments, and coinsurance amounts under the terms of my medical plan.

NAME (please print) _____

SIGNATURE _____ **DATE** _____