NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I give permission to share medical and billing information with the person/persons named below:

Name:_____

Name:_____

Do we have permission to leave the following information on your voicemail? (Circle one)
Appointment information: Yes No Billing Information: Yes No Medical Information: Yes No

Do we have permission to call you for a yearly reminder that you are due for your eye exam? Yes No

I hereby give consent to Bayshore Eye Care and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations. My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, and future physical and mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We have the right to change terms of our Notice of Privacy Practices.

By signing below, I acknowledge that I have reviewed or have been given a copy of Bayshore Eye Care's Notice of Privacy Practices at my request.
PAYMENT POLICY: Payment is due the date when services are rendered. If we are billing insurance, you will be responsible for your co-pays, refraction, co-insurance, and/or deductibles. You will be responsible for the remainder of your examination if your insurance does not pay within 45 days.

Patient or Patient Representative_____Date_____

SIGN BELOW IF WE ARE BILLING INSURANCE ON YOUR BEHALF

We are a provider for most medical insurances and many vision plans. **If you are coming in to have a medical complaint or condition addressed, we are required to bill your MEDICAL INSURANCE for your eye exam. Many times we can still check your prescription even though we are evaluating a medical problem. If you are coming in for a routine vision exam to have your glasses and/or contact lenses updated, we will bill your ROUTINE VISION PLAN.** By signing below, you give us permission to choose whether to bill your medical plan or vision plan depending on the reason for the visit.

I hereby authorize the physician to release any information required to process this claim. If the physician is accepting insurance, I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions.

Patient or Patient Representative_____Date_____

SIGN BELOW IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH INSURANCE

I request that payment of authorized Medicare benefits be made to Kenneth W. Lawson OD or Jamie S. Lawson OD. for services rendered to me by him/her. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents regarding any information needed to determine these benefits. I understand my signature authorizes that payment be made and permits release of medical information necessary to pay this claim. If other health insurance is listed in item 9 of CMS 1500 or elsewhere, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Dr. Kenneth Lawson or Dr. Jamie Lawson agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, copayments, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____Date_____