Receipt of Notice of Privacy Policies & Consent Form

7119 Elk Grove Blvd. #123

(916) 478-2778 fax (916) 478-2779

Patient Name: ____________________________

Patient Phone #: ____________________________

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 health care operations involving our office.

The *Notice of Privacy Practices* describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriated for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtain payment; (2) our submission of claims to third- party payers or insures for claims review, determination of benefits and payments; (3) our submission of your health information to auditors hired by a third- party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you understand our *Notice of Privacy Practices*. You have the right to ask us to restrict the uses or disclosures made for perform healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from *Axis Eye Optometric Group.*

____________________________ ____________________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

____________________________ ____________________________

Relationship to the Patient Print Name

Source of Authority: ____________________________

FINANCIAL POLICY

Thank you for choosing our practice for your vision needs. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

Please complete the policy form and place your initials where indicated.

_______ **UNINSURED PATIENTS**: Payment in full is due at the time of service for all office visits, procedures, exams, glasses and contact lenses unless other agreements are made in advance. We except cash, checks, MasterCard, Visa, and Discover.

INSURANCE:

It is your responsibility to know your insurance plan and to verify your coverage. We make every effort to help you with this however there are more than 50 plans for which we are providers, and it is not possible for us to know the details of each of these plans.

_______ **VSP/EYEMED/MESC**: All co-pays/overages are due at the time of service

_______ **HMO**: We are not a HMO. If you choose to see us as an out-of-network provider, all charges are due at the time of service.

_______ **PPO**: We will bill your insurance company. This is not a guarantee of payment from the insurance company. Services not covered or balances after insurance pays will be the patients' responsibility. Co-pays and overages are due at the time of service. You must bring a copy of your current card for us to bill.

MINORS: The parents or guardians of a minor are responsible for full payment.

Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, usual and customary charges, etc. other than to supply information as necessary. You are ultimately responsible for the timely payment of your account.

I have read and understand the above information.

______________________ ______________________ ______________

(Printed Name) (Signature) (Date)

Responsible Party's name (parent or guardian of patient under 18)

______________________ ______________________ ______________

(Printed Name) (Signature) (Date)