FINANCIAL, HIPAA & RELEASE OF INFORMATION POLICY

Medicare:

We accept Medicare assignment; however, the Medicare patient is responsible for the deductible as well as the difference between the allowable charge and the amount Medicare pays.

Refraction fees are a Medicare non-covered service and the patient is responsible for this charge.

Supplemental insurance (if applicable) will be billed for this service and any remaining balance will become the responsibility of the patient.

HMO/PPO/Commercial:

All co-payments and account balances are due at time of service.

Patients are responsible for confirming their insurance is active and that we are participating providers in their plan.

Self-Pay:

A minimum payment of $50.00 is due at the time of service for all self-pay patients.

All subsequent visit charges will also be due at the time of service.

Workers' Compensation:

If your visit is due to a work-related injury, we will require both health insurance and your employer's Worker's Compensation insurance information, including the claim number, insurance address, adjuster's name and contact information.

All unpaid Worker's Compensation balances become the responsibility of the patient.

I Understand:

*****I may be liable for the full cost of services provided if I do not provide the correct insurance information within the TIMELY FILING LIMIT (usually 60 days from the date of service) set by my insurance carrier.

*****My insurance company may pay less than the actual billed amount for services and I am responsible for the remaining balance as well as any charges that the insurance carrier deems a "non-covered service".

*****If my insurance carrier requires a referral, it is my responsibility to get the referral from my Primary Care Physician prior to seeing a specialist and to obtain a new referral when a previous one has expired or I have used the allowed number of visits.

*****Unpaid balances that remain outstanding after 2 billing cycles may be turned over to a collection agency and I will be responsible for the collections costs as well as the unpaid balance.

*****Failure to keep this account current may result in my being discharged from the practice.

*****I may be charged $25.00 for each missed appointment that is not cancelled within 24 hours of my appointment time.

*****This fee is not covered by insurance and must be paid prior to my next appointment.

*****Multiple missed appointments may result in termination from the practice.

HIPAA Acknowledgement:

I know my rights regarding my protected health information are governed by the Health Insurance Portability and Accountability Act of 1996. I have been informed of and given the opportunity to review a copy of Norwich Ophthalmology Group's Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information. I understand that Norwich Ophthalmology Group complies with the Public Act No. 08-167 concerning the confidentiality of social security numbers.

Release of Information:

I authorize my health care provider and their representative to release any information relating to illness, injury, diagnosis, or treatment to my insurance carrier, health plan, third party payer, their agents, contractors, subcontractors, or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to, any medical records and medical information. I understand that the reason for furnishing such information may include the following: use in medical, financial, and or provider auditing or such other auditing as may be legally required for utilization and/or quality of care review and assessment and of determining available health benefits and coverage.

Signature: _____Date: _____