AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION: Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Responsible Party Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No If yes: Work Phone: _____ Extension: _____

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

PRIOR EXPRESS CONSENT: Pediatric Ophthalmology and Strabismus, Inc. and Pediatric Eyewear, Ltd. (POS/PEL) are in compliance with Health Insurance Portability and Accessibility Act of 1996 (HIPAA), designed to tell you how we may, under federal law, use or disclose your health information. I understand the risks associated with communication by email. Precautions will be taken to preserve the confidentiality of emails between POS/PEL and patients. However, this cannot be guaranteed and sensitive material should be conveyed by more secured methods. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing a primary & secondary number, I consent to receiving such calls at the number(s) I provided. Opting in is not required for medical treatment. My information will not be disclosed or sold to any 3rd parties.

PROOF OF INSURANCE: All patients must complete the registration process. I must provide POS/PEL my current primary and secondary (if applicable) insurance card(s) to copy. I understand that I am responsible for payment of all services rendered if I do not have my card available.

FINANCIAL POLICY: I understand that my insurance coverage is a contract between me and my insurance carrier. As a courtesy to our patients, POS/PEL will submit claims to your insurance carrier using appropriate billing and coding guidelines. We cannot predict nor guarantee what part of our services, if any, will or will not be covered by your particular plan. *I am responsible for paying all co-insurance, copayments, deductibles, and charges for noncovered services.* Payment is expected in full when services are rendered, unless other arrangements have been made in advance. There is a $25.00 service fee for any patient balances greater than 90 days.

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I request that payment of authorized insurance benefits be made on my behalf to POS/PEL for all services provided. I authorize any holder of medical information to release all necessary information needed to determine my insurance benefits payable for services rendered. *I am financially responsible for charges not covered by my insurance.*

RELEASE: I agree that recognizable photographs and/or video documentation and description of me or my child(s) eye(s) may be published in medical journals or be presented to scientific medical groups and will not be altered.

DECLARATION: Our doctors and chief optician declare a financial interest in our eyewear shop - Pediatric Eyewear, Ltd.

Patient (if 18+ years) or Parent/Legal Guardian PRINT NAME _____

Patient (if 18+ years) or Parent/Legal Guardian SIGNATURE _____

DATE _____

*** A copy of this signature is as valid as an original ****

UPDATED

DATE **INITIALS**

C: admin/hippa/patient registration back.doc111717