VISION SOURCE®

Dr. Shonda D. Achord, Optometrist

PATIENT NAME (please print)

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice (copy available upon request) before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used and disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have made on reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment or healthcare operations.**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **The Practice may condition receipt of treatment upon the execution of this Consent.**

Do you give us permission to discuss your medical record with anyone? (Specify name, date of birth and relationship.)

Name:_____ **DOB** _____ **Relationship** _____

Name:_____ **DOB** _____ **Relationship** _____

➡ **Responsible Party Signature**_____ **Date** _____

Print Name _____ **Relationship** (if other than patient) _____

FINANCIAL RESPONSIBILITY & INSURANCE SIGNATURE ON FILE

- **We will gladly file your insurance; however, you will be responsible for any charges your insurance company does not pay. If your insurance company does not pay within 45 days of the date the claim was submitted, you will be billed for the balance. If your insurance company pays after this date, we will reimburse you.**
- **Please be aware that many insurance plans require that you see an "in-network" provider. Many plans also have restrictions on how often they will pay, i.e. one exam 12 months from the last date of service. Please also be aware that insurance benefits are sometimes misquoted by customer service representatives, and we can only go by the information we are given. We will verify your insurance coverage whenever possible; however, you are ultimately responsible for knowing your insurance coverage and eligibility.**
- **We are required to accept certain allowances for services with the insurance companies with which we are contracted; however, we are not required to accept the allowances of other insurance companies with which we are not contracted. You will be responsible for paying the amount the insurance company does not pay.**

I have read the above insurance policies of Vision Source – Dr. Shonda D. Achord, Optometrist, and I agree to pay any charges that my insurance company does not pay. I understand that some services may not be covered, as dictated by my insurance company. If my insurance company denies the claim as a non-covered service, I understand that I will be responsible for the balance. If my account becomes delinquent, I agree to pay all collection costs, including attorney fees.

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Vision Source—Dr. Shonda D. Achord, Optometrist on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to HCFA any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

➡ **Responsible Party Signature**_____ **Date** _____

Print Name _____ **Relationship** (if other than patient) _____