ADVANCED FAMILY EYE CARE

400 7th Street, Ellwood City PA 16117
214 W. New Castle Street, Zelienople PA 16063

Authorization for Insurance Submission

I agree to pay for all services rendered and the materials fabricated at my request. I request that payment of authorized Medical/Vision insurance benefits be made on my behalf to Family Eye care for any services provided to me by that provider.

Responsibility of Payment of Services Rendered

I agree to pay for services rendered and materials fabricated at my request and acknowledge that my insurance company can deny payment for service. I agree that if my insurance carrier does not pay Family Eye Care within 90 days after submission, for services rendered to me, I shall take full responsibility for these charges. If an insurance payment is received after I have reconciled with Family Eye Care, I will be refunded the amount of payment stated on the "explanation of benefits" provided by my carrier.

Health Insurance Portability and Accountability Act of 1996 (Notice of Privacy Acknowledgement)

We respect our legal obligation and your rights to privacy by maintaining your medical records in complete confidentiality and obligated by law (HIPAA) to give you such notice. Based on the HIPAA regulations, we cannot share or disclose information from your medical records without written consent. This implies any and all non-medical or non-licensed healthcare offices or third party vendors. We ask you to sign this form to allow us to disclose only the information required to:

1) Have other **licensed medical providers** who might/will assist in your medical and/or eye care.
2) Your **insurance carrier** in order to process claims and/or a federal or state agency mandates for public health concerns.
3) If a copy of a record is requested by yourself or a designated guardian, a separate "Record Release" form must be signed by the individual. Records can then be released to the authorized party.
4) Your records are held safe within the confines of our office with limited access to doctors and staff.

I acknowledge that I have received the Notice of Privacy Acknowledgement. I understand that I may request, in writing, that Family Eye Care restricts how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that the provider is not required to agree to requested restrictions, but if so the provider is bound to abide by my restrictions.

X

Signature of Patient or Representative | Print Name of Patient or Representative | Date