

## Patient information form and hipaa privacy information

Assignment and release: I certify that I (or my dependant) have insurance coverage as indicated on the intake form and assign directly to Lansdowne eye associates, pc all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all fees when insurance information is not provided , provided incorrectly, provided after service has been delivered or under the new hipaa policy have elected not to allow Lansdowne eye associates, pc to submit information on my behalf.

I understand that all insurance carriers have different rules and most require that forms / referrals be presented prior to receiving non-urgent service or care. I understand that if I have not presented the proper forms before service is rendered that I am responsible for the bill in its entirety as well as any fees incurred to collect the above fees. A fee may be assessed if forms must be obtained at the time of the appointment for non-urgent care or routine care.

Emergency services or after hours service will have an additional co-payment of \$20.00 in addition to your regular co-payment.

For patients with medical coverage: the non-medical, typically the refraction portion of the examination ( which is the determination of your eyeglass prescription) or evaluation for contact lenses is not covered and has a separate fee.

For patients with vision coverage only: the medical portion of the examination (such as follow-up care for glaucoma, cataracts, floaters, sore/red eyes, macular degeneration, diabetes) is not included, and will have a separate fee – we do **screen** for glaucoma ,cataracts and other medical eye conditions under your normal vision examination and this is included, additional testing and treatment is medical and will be billed through your medical insurance with the appropriate co-payments and referrals required.

For patients with both medical and vision coverage: we will use both coverages for each portion of the examination. You will have two (2) co-payments, one for each portion of the examination when applicable. Due to insurance regulations, we are not able to waive co-payments.

For patients with a vision plan: we prefer for you to select your eyewear at the time of examination, because we dilate (use drops), we recommend that you arrive early for your appointment. Should you elect to select your eyewear on another date, we will gladly hold your form for one week. You may use your benefits after that time (if your plan allows) but we charge a \$12.00 service fee (not a co-payment) to reprocess the form and for the additional office time – this is an additional fee to any co-payments.

For eyewear fabricated under vision insurance plans: unless selected as an upgrade there is no warranty on the frame or lenses after 45 days from the date of the examination. If your plans specifically provides a warranty on the materials beyond the 45 days there will be a co-payment for the service provided by our office. All warranty service provided by the plan will be sent back to the fabricating laboratory – we will gladly provide the service in house for an additional fee.

I understand that a deposit is required on all ophthalmic services (glasses, contact lenses or special order materials). Extended billing for discounted services or materials will nullify the discount unless prior payment arrangements have been made. A Cost savings analysis for vision plans has been provided and signature below complies with all plan requirements.

Initial: \_\_\_\_\_

All co-payments must be made at the time of service. Co-payments on materials must be paid in full prior to the laboratory processing the order unless prior arrangements have been made. Any co-payments not fully paid within 30 days from the start of service will be subject to a service fee and will nullify any and all plan discounts.

I understand that filling my prescription is the same as providing the prescription in written format. We will gladly provide you with one additional copy of your prescription (glasses and contact lenses when the necessary examinations have been performed and the prescription is not expired). Additional copies of your written non-expired prescription will be provided at a nominal fee of \$2.00 / copy or fax). Optical prescriptions will not be provided orally except when requested emergently by a licensed practitioner. A copy of an expired spectacle prescription or contact lens prescription which is less than two (2) years old will be provided at a fee of \$5.00 / copy and will indicate that the prescription is expired – this is provided for informational purposes only.

We will gladly fill out school vision forms, driver's forms, etc. at the time of your appointment – forms that must be filled out after the examination will have a nominal fee of \$5.00/form and may require additional testing if the form requests information not typically performed during a routine vision examination.

All returned checks are subject to a service fee of \$25.00.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Hipaa privacy information : the complete privacy policy is posted in the office – you may have a copy; ***the form you are currently reading must be signed prior to delivery of any services and indicates that you have read and are aware of the privacy policy..***

1. we do not use your medical information for any purpose other than providing care
2. we do not release your medical information except to provide care, to receive reimbursement or upon the audit by your insurance company.
3. your information is your property – you may always see your record or have copies made. Copies are \$1.00/page for current records (2 years or less) and \$2.00/page for records over 2 years old. Some records contain color photographs or color images – these images will only be reproduced when requested and are available at \$5.00 / page
4. if records require any interpretation by the doctor – this will be billed on a fee for service basis, minimum 1 hour and then 0.25 hour increments.
5. records over 2 years old are archived and may take up to 7 days to access, if emergent you must notify us and we will provide records emergently at an additional fee.
6. records under 2 years old are available in 2 business days at no additional fee and emergently, if available, sooner, also at no additional fee. Occasionally records are removed from the office for billing purposes and are not readily available.
7. we **do call to confirm** appointments and **do call** when ophthalmic materials (contacts and glasses) are available for dispensing.
8. We do occasionally send out postcards as appointment reminders or for missed appointments or when you are not available by telephone – if you do not want us to provide this service please initial [ \_\_\_\_\_ ]
9. we do not typically discuss you case with other people but if there is someone specific that **should not have access** to your information please provide their name below:

a. \_\_\_\_\_

b. \_\_\_\_\_

Initial: \_\_\_\_\_

I authorize the use of my medical information to staff members of Lansdowne eye associates, pc as well as to any other practitioner that may be participating in my medical care in order to provide the best care. This information may be transmitted in any format that best expedites my care.

I have read and fully understand the above information and have been given the opportunity to ask any questions about the above information and it has been properly explained to my satisfaction.

Responsible party signature: \_\_\_\_\_ Date: \_\_\_\_\_



**ONLY SIGN BELOW IF YOU WANT YOUR INFORMATION COMPLETELY CONFIDENTIAL WHICH INCLUDES SUBMITTING FOR INSURANCE REIMBURSEMENT**

**If you have information on your record that you wish to remain private – you must sign below and specifically indicate the information that we must keep private.**

Information to remain confidential unless required by law or subpoena to be released – signing below requires that your health care services be provided on a fee for service basis and you must submit for reimbursement for the services provided.

[ ] all information in my record to be kept confidential to all parties  
[ ] \_\_\_\_\_

**MY SIGNATURE BELOW INDICATES THAT I WILL PAY FOR ALL SERVICES AT THE TIME OF SERVICE, AND ELECT FOR LANSDOWNE EYE ASSOCIATES NOT TO SUBMIT TO MY INSURANCE CARRIER FOR REIMBURSEMENT.**

Responsible party signature: \_\_\_\_\_ Date: \_\_\_\_\_