HIPAA Compliance Acknowledgement of Receipt:

I acknowledge that I received a copy of Mt. Airy Eye Care notice of privacy practices.

Vision vs. Medical Plans

If my Optometrist finds that I am at risk of an eye disease or eye disorder:

- I will be made aware when additional testing and evaluation is necessary to manage my eye health and sight.
- Any testing for my eye health will be billed to my Medical Health Insurance
- I am aware co-payments and co-insurance are my responsibility at the time of service.
- **Referrals are required at the time of service, otherwise patient is responsible for full payment.**

I understand:

- Mt. Airy Eye Care will submit both vision and medical claims when appropriate in order to maximize benefits
- Both my vision and medical insurances may have co-pays and deductibles, which are due at the time of service
- For initial treatment and any prescribed follow-up treatment, my vision plan or medical health insurance determines the co-pay or co-insurance that is due at time of service for each visit.

Patient or Guardian Signature:___________________________________Date:___/___/_____

If you are using insurance, please complete the following section:

Name of insurance____

Primary insured's name_______________________Relationship to patient_____________________

Policy #______________________ Group# _______________________ Primary DOB___/___/_____

(Please note that verification of Insurance does not guarantee payment from the insurance company)

Lifetime Patient Signature (Your signature below is required to bill your insurance company)

I authorize any holder of medical information about me to release to my insurance company or Center For Medicare Services and its agent any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to Mt. Airy Eye Care, LLC, I will be held responsible for said service(s) and or product(s).

Patient or Guardian Signature: ______________________________**Date**:___/___/_____

☐ **Please do not discuss my health care information with anyone else**

☐ **Please only discuss my health care information with those listed below**

Name___________________________Relationship_____________DOB___/___/_____

Signature:____Date____/____/______