SIGNATURE ON FILE

I request that payment of Medical/Medicare/Vision Insurance benefits be made on behalf of (patient's name)_____**,** for services furnished to me by Harwood Vision Clinic. I authorize any holder of medical information about me, to be released to the Centers for Medicare and Medicaid Services and its agents, including any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health information is indicated in Item 9 of CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing information to the insurer or agency shown. Harwood Vision Clinic accepts the charge determination of Medical/Medicare/Vision Insurance carrier as the full charge, and the patient is responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier.

INSURANCE REQUIREMENTS

We will be happy to file your insurance claim forms or to take assignment of your vision and/or benefits as designated by your insurance company. We are happy to provide this service without any additional charge to you. We will do all that we can to help you receive the maximum benefits. **However, it is your responsibility to know your insurance plan's requirements and benefits** and to notify the staff at Harwood Vision Clinic. Lack of proper identification could result in you being responsible for all charges, and insurance claims will not be submitted after services are rendered. We will gladly supply you the proper paperwork for you to submit your claim.

We go to great lengths to verify the amount and type of coverage you are allowed under your plan. We can quote your estimated coverage; however final determination of benefits will not occur until the insurance company receives your claim. In the event the plan sponsor determines that you are not eligible at the time of service, or determines that you are eligible for a reduced benefit level, or applies the charges to the deductible, by signing this statement you agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor. **We will notify you of the balance due. By signing this document, you agree that we may use the credit card on file to collect the balance.** If you do NOT agree to this payment arrangement, you will be expected to pay for all services in advance. Any balance on your account is due within 30 days. If not, a monthly finance charge of 1.5% will apply.

PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

I acknowledge that a copy of Harwood Vision Clinic's Privacy Practices has been made available to me**. I agree to be financially responsible for any fees incurred as a result of today's services and/or materials provided, including those not covered by insurance.**

SignatureX_____Date_____

E-Mail Address:_____

Primary Telephone Number:_____

HIPAA RELEASE FORM

Name:_____ Date:_____

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #

Patient Signature: X_____