

INSURANCE/BILLING/HIPAA POLICY STATEMENT SUMMARY

COMPLETE FRONT & BACK SIGN APPROPRIATE METHOD OF PAYMENT & BRING INSURANCE CARDS TO APPOINTMENT

*This document is a **condensed version** of Center For Sight's Insurance/Billing/HIPAA Policy Statement. Out detailed Policy Statement and Notice of Privacy Practices is posted in our office and you are encouraged to read it. If you would like a copy of each of these Policies, please ask the person at the front desk.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING:

*you were informed of these forms *your right to receive a copy of them *your agreement to the Policy.

The key items of the Insurance/Billing Policy are:

It is the **RESPONSIBILITY OF THE PATIENT to know you require a referral, pre-certification or second opinion.

We will file your insurance if we have: all necessary information 2) copy of insurance card/s **and you have a medical diagnosis (determination of glasses refraction is non covered).**

SELF-PAY

SELF-PAY: I understand payment is my responsibility due to no insurance coverage or other reasons.

CK _____ Cash C.C _____

(Signature)

(Date)

INSURANCE

INSURANCE:

AUTHORIZATION: I authorize Center for Sight to release any information in the course of my examination of treatment and permit payment directly to him or her, any benefits due for this service. **I recognize and accept personal responsibility for any balance or fee not covered.** If the insurance company pays me directly for services rendered, I will immediately forward that payment to Center For Sight.

(Signature)

(Date)

MEDICARE

MEDICARE: I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

(Signature)

(Print Name)

(Date)

(Witness)

(Print Name)

(Date)

HIPAA

By signing below, you are acknowledging that you were informed of our Notice of Privacy Practices and of your right to receive a copy of it.

(Signature of Patient or Legal Representative)

(Date)

FOR CENTER FOR SIGHT USE ONLY: Staff was unable to obtain Acknowledgement of Notice for the

following reasons: _____ **Staff initial and date:** _____

FOR CENTER FOR SIGHT USE ONLY: I have obtained the proper signatures and entered patient demographic information. Staff initial _____ Date: _____

PRIMARY INSURANCE

SUBSCRIBER NAME	SUBSCRIBER DOB	SUBSCRIBER SSN:	PATIENT/SUBSCRIBER RELATION: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
EMPLOYER	ADDRESS	CITY/ST/ZIP	PHONE ()

SECONDARY INSURANCE

SUBSCRIBER NAME	SUBSCRIBER DOB	SUBSCRIBER SSN:	PATIENT/SUBSCRIBER RELATION: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
EMPLOYER	ADDRESS	CITY/ST/ZIP	PHONE ()

COPY INSURANCE CARDS HERE

Is this related to an injury Yes No

Date of Injury _____ Type of Injury Work Auto Other _____