PATIENT ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** describes in detail how your health information may be used and disclosed, and how you can access your information. By signing below, you acknowledge that you have been offered the opportunity to receive the Notice of Privacy Practices of the Vision Health Institute. Our privacy practices are posted online at www.myVHI.com.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

CONSENT OF DISCLOSURE

FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

During the course of providing service to you, we create, receive, and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to safeguard your confidentiality. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations, which includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but also disclosures of your health information, as may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but is not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies, including optical personnel will have access to your health information.
- The payment of medical insurance benefits to the Vision Health Institute, Perry Eye Care Associates or Vision Developments or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

By signing below, you acknowledge that you have read and understand the above information and voluntarily consent to the statements herein.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

INSURANCE IDENTIFICATION AND OUR FINANCIAL POLICY

- **Please provide your insurance identification** card and picture ID. These will be photocopied for identification purposes before the examination. A photograph will be captured in our electronic health records for identification purposes. Third party insurance benefits will not be honored without your proper identification card and picture ID.
- **You will be responsible for all professional fees at the time of service** on materials and services if we cannot verify eligibility of benefits at the time of the exam
- **Prior authorization of insurance benefits must be verified** from your insurance company before your examination.
- **After the date of service, we will not be responsible to file or recover insurance benefit payments** for which we were not able to verify on or before the date of service. Accounting adjustments, discounts or credits due to insurance will not be provided at a later date.
- **It is our pleasure to assist you in filing your insurance benefits** if we cannot verify eligibility of benefits on or by the date of service. You will be responsible to correspond directly with your insurance company to recover any professional service or material fees.

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of subsiding professional fees for the patient and are generally paid directly to the doctor. Health insurance eligibility does not guarantee payment for services or materials and is not a substitute for your responsibility to payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance policy benefits and obligations. This includes all financial obligations for services and materials.
- Health care regulations require the collection of all co-payments, deductibles, balances and non-covered professional fees at the time of service. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. Examination fees and co-payments are collected at the time you receive services. Insurance co-payments are collected at *every* visit.
- If your insurance company does not pay for professional services and/or materials within a ninety-day period, we have the right to bill you for the balance of your account. Prolonged unpaid balances are reported to a collection agency and may affect your credit rating.
- Some insurance companies only pay a portion of the professional fees (fixed allowances or percentages). Depending on your plan, you will be required to pay any outstanding balance on your account.
- Certain procedures, such as contact lens fittings, are elective and not covered by insurance benefits. You will be responsible for all professional fees for any non-covered services at the time rendered.
- Discounts and promotional coupons are not accepted in conjunction with any insurance benefit or third party program or other discount coupons,

By signing below, I acknowledge that

- ☐ I have read and understand the financial policy of the Vision Health Institute.
- ☐ I accept financial responsibility for all professional services and materials provided by the Vision Health Institute.
- ☐ I understand that I will be responsible for any unpaid balance on my account in the event my third party insurance plan neglects to pay any balance due or fails to fulfill the contractual obligations.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

Thank you for your confidence in our professional services and practice.
We look forward to serving you.

This form is retained in your electronic medical record