Family Vision Care

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131 GA Hwy. 32 Bypass • Alma, GA 31510

PATIENT AGREEMENT FORM

Notice of Privacy Practices

By signing this form below, I acknowledge I have been provided with Family Vision Care's "Notice of Privacy Practices" to review, and informed that I may keep a copy for reference or obtain a copy upon request.

HIPAA & Release of Information

Family Vision Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Family Vision Care for reimbursement for services rendered, and (2) any health care provider for continued patient care. Family Vision Care may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Release of Information to Individuals: Family Vision Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to the individual(s) provided below:

Name	Relationship	Phone
Name	Relationship	Phone

Patient's Financial Responsibilities

Financial Responsibility: Medical services provided by Family Vision Care imply financial responsibility on my part; by signing below, I agree this responsibility obligates me to ensure payment in full for services rendered.

Covered Services: Family Vision Care will make all efforts to send claims to the health care service plan on file. I agree to provide current and accurate health care service plan information to Family Vision Care. Proof of insurance and photo ID is required for health service plans to be billed for services. Proof of insurance does not confirm that services are covered or effective at the time of service. If I fail to provide health care service plan information in a timely manner, I am financially responsible.

Non-Covered Services: I understand that Family Vision Care contracts with health care service plans (i.e., HMOs, PPOs) related only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, the REFRACTION FEE, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient, and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Family Vision Care to obtain necessary health care service plan authorizations.

Credit to Patient Account: Patient credits will be issued to the patient in check form unless the credit is valued at less than ten US dollars; if the credit is less than ten dollars, the patient's credit will be applied to their Family Vision Care account to be applied to any future balance.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Family Vision Care, for services furnished me by Family Vision Care. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for 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 care service plan is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Family Vision Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Medigap: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Family Vision Care if possible, or otherwise to me.

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PATIENT OR AUTHORIZED PARTY SIGNATURE **DATE**