



**FINANCIAL POLICY**

**and**

**PRIVACY PRACTICES ACKNOWLEDGMENT FORM**

Notice of Privacy Practices Acknowledgement. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received or have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I consent to ProCare Vision Center using and disclosing my protected health information to carry out treatment, payment, or health care operations. A printed copy of the Notice of Privacy Practices is available to you upon request.

**Payment is expected at the time of service.** Financial Responsibility. I understand that all benefits quoted to me are NOT at guarantee of payments by my insurance company and that final determination can only be made after the claim is processed. I also authorize payment of benefits directly to ProCare Vision Center and its providers for such services provided for me and my dependent(s). I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred by the above- named patient, and I agree that **I AM FINANCIALLY RESPONSIBLE** for any remaining balance, should my insurance carrier determine the services I received are not covered.

I understand that accounts past 90 days old are subject to collection fees. In addition, there will be service charges for any method of payments resulting from Non-Sufficient Funds or Stop Payments or Credit Card Chargebacks.

I authorize the release of any medical information necessary to process insurance claims for services provided to me by providers at ProCare Vision Center. A photocopy of this authorization shall be considered valid.

For patients who have vision/health insurance please remember it is your responsibility to make sure that you are eligible for an exam at the time of your visit. You will be asked to pay for your visit in full if you are found to be ineligible for an exam. If we participate in your vision/health insurance plan, we will be happy to submit a claim to your insurance carrier. You are responsible for paying any co-payments or deductibles at the time of your visit. You will be asked to pay for your visit if you do not have your health insurance card, physician referral or completed claim form if one is supposed to be provided. We ask that you notify us of any pre-certification or special limitations that may exist with your insurance carrier.

Your signature below provides for the release of any medical information necessary to process all insurance claims that the medical payment will be made directly to ProCare Vision Center. Regardless of your insurance benefits, if any, you are financially responsible for all fees incurred for services rendered.

My signature below indicates I have read, understand, and agree with the above statements regarding the notice of privacy practices and financial responsibility.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_