Better Visions, PC Acknowledgement of Services Confirmation, HIPAA, PHI, Reassign Benefits Form

Disclosure: Any medical diagnosis with any service code (i.e. health exam, photography, visual field, testing) is required to be billed to your medical insurance plan, not your vision plan. Any medical diagnosis overrides refractive diagnosis.

Signature:_____ Date:_____

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I hereby acknowledge that I have been presented with the **Notice of Privacy Policy of Better Visions, PC** and have been offered a copy of such policy to keep for my records on the following:

I allow **Better Visions, PC** to use and disclose ONLY necessary personal health identification, such as my name, address, eye examination information, health diagnosis for eye and systemic disease, and insurance policy card numbers and type of products provided, to all of my insurance companies to permit **Better Visions, PC** to perform its administrative duties provided me with eye care services and products, process all of my benefit claims, and communicate with me regarding vision care services and products; for exam, mailing of exam reminders/services, fax, and answering machines. I understand the information once disclosed under this authorization may be subject to re-disclosure and no longer protected by privacy regulations. My signature also allows **Better Visions, PC** to receive payment for services for patients with accepted assignments. I further understand this authorization is valid for **one (1) year** unless revoked by me in writing prior to that time. I agree to pay any balance due for services provided. If my balance is sent to collections I agree to pay court costs, 18% interest, collections costs, and reasonable attorney fees.

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to **Better Visions, PC** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

*Signature: _____ Date: _____

**Patient Name: _____ *Name of Minor Signed for: _____

⬜ I CHOSE TO TAKE A COPY OF THIS NOTICE ⬜ I DECLINED TO TAKE A COPY OF THIS NOTICE

ONLY YOU OR THE NAMES/AGENCIES BELOW MAY HAVE ACCESS TO YOUR INFORMATION. IF THE NAME IS NOT ON THIS DOCUMENT, NO INFORMATION MAY BE RELEASED FROM THIS OFFICE.

NAME/AGENCY: _____ RELATIONSHIP: _____

NAME/AGENCY: _____ RELATIONSHIP: _____

NAME/AGENCY: _____ RELATIONSHIP: _____

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MEDICARE PATIENT'S ASSIGNMENT OF BENEFITS

I authorize Better Visions, PC to release any medical or other information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Medicare Covered Items: Medical portion of eye examination ***if*** there is a **medical diagnosis**, cataract post operative care, glaucoma care, and testing.
Medicare Does Not Cover: Routine eye exams, refraction(calculates your prescription), glasses after laser or cataract surgery, multiple services or multiple visits. I acknowledge my insurance company(ies) are expected to pay my bill for Better Visions. I agree to allow claims to be filed using my personal information. Better Visions, PC can receive payment for the benefit. I am obligated and will be responsible for all applicable co-payments as well as any balance should my insurance company(ies) not pay my claim.

_____
Signature of Beneficiary, Guardian, or Personal Representative

_____
Please Print Name of Beneficiary, Guardian, or Personal Representative

_____
Date

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