VillageEyeCare, LLC

Using Your Insurance

Benefits quoted to us by your insurance company are only an **estimate** of coverage and are **not a guarantee** of payment.

- In most cases, we can only bill your ***primary insurance***. We can provide you with the necessary paperwork to bill your secondary and be reimbursed directly.
- It takes most insurance companies 1-3 months to process a claim.
- We do our best to get an accurate quote of your benefits, but insurances may quote the wrong benefits, omit co-pays and deductibles or say you are eligible when you're not.
- Should your insurance not pay as much as estimated or deny the claim, you are responsible for the balance.
- Should it become necessary, you are responsible for the cost of any collections proceedings, court costs and reasonable legal fees.

Privacy Practices: HIPAA Omnibus Rule

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we cannot process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR TEST RESULTS BE SENT TO ANOTHER DOCTOR / FACILITY IN THE FUTURE. IN ADDITION MY SIGNATURE WILL SERVE AS AUTHORIZATION TO BILL MY INSURANCE.**

_____	_____	_____
Please ***print*** your name	Please ***sign*** your name	Date
_____	_____	
Legal Representative if unable to sign	Description of Authority	

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
If left blank, we cannot release any health or financial information to anyone other than yourself. This includes spouse, step parents, grandparents and any care takers who can have access to this patient's records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not specify below, you are indicating that any of the listed methods are acceptable:

I AUTHORIZE CONTACT FROM THIS OFFICE TO:

- **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:
- **CONVEY INFORMATION ABOUT MY HEALTH** VIA:
- **CONTACT ME ABOUT SPECIAL SERVICES, EVENTS, NEW HEALTH INFO** VIA:

☐ **Any method**
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

☐ It was emergency treatment
☐ The patient refused to sign
☐ The patient was unable to sign because
☐ I could not communicate with the patient
☐ Other (please describe)

_____
Signature of Privacy Officer