INSURANCE VERIFICATION AND HIPAA RELEASE

PLEASE READ AND SIGN:

IF YOU ARE USING MEDICAL/VISION INSURANCE FOR TODAY'S SERVICES:

Insurance information is required at the time services are performed. I hereby authorize Primary Eyecare Associates to release or exchange any information necessary to process any insurance claim. In the event any such coverage is denied, I will be billed and I will be held financially responsible for services rendered. Additional charges may apply in lieu of insurance benefits.

Primary Eyecare Associates does not coordinate benefits between your insurance carriers unless the office manager has approved prior authorization. Primary Eyecare Associates will NOT accept or process insurance benefits if discovered after services have been rendered.

In the event that your routine vision evaluation becomes a medical visit, we will bill your medical insurance, not your vision insurance.

I certify that I have reviewed a copy of the "Notice of Privacy Practices"

Patient or responsible party signature:

_____ Date _____

Notice: Failure to sign the above agreement will prevent Primary Eyecare Associates to provide services.

HMO MEMBERS WITHOUT A REFERRAL FOR TODAY'S SERVICES ONLY:

PLEASE READ AND SIGN:

I understand that my insurance company requires a referral for today's services. I do not have this referral. I fully understand that Primary Eyecare Associates will not bill my insurance for the services rendered and agree to be responsible and pay in full for all services today.

Patient or responsible party signature:

_____ Date _____