HIPAA POLICY AND PATIENT INSURANCE AUTHORIZATION

This office follows the recommended patient privacy policies. Please read our HIPAA policy for more detailed information. To provide the best care, the physicians and staff of this office may need to contact you in reference to an appointment, scheduled test or treatment, or products ordered for your care. In accordance with privacy laws, we will not disclose patient Protected Health Information to anyone other than the patient, or those individuals designated by you.

In addition, this form authorizes us to bill your insurance company for the services rendered. It is your responsibility to provide the current and correct insurance information. You are responsible for the balance of charges that your insurance does not cover.

The following statements authorize the physicians and staff of this office to release medical information and to bill your insurance. Please enter your initials next to the statement authorized by you, and sign the bottom of this form. You may update these authorizations in writing at any time.

_____ I have read the HIPAA policy provided to me by the office of Kennett Square Eye Care.

_____ I authorize the office of Kennett Square Eye Care to leave a detailed message about my health care, test results, or products ordered at the following phone number(s). Please indicate preference:

Cell number:

Home number:

Work number:

_____ I am over 18 and authorize this practice to disclose any and all medical information to the following individuals:

Name(s) and relationship(s):

_____ I understand that it is my responsibility to notify the office of my current medical and vision insurance coverage. If the information provided is not up-to-date or the insurance company does not cover the charges necessary for accepted standard of care, I understand that I am responsible for payment.

Thank you for filling out this authorization form to help us provide the best care for you and your family.

Patient Name _____

Patient Signature _____ Date _____