Tekwani Vision Center

PATIENT ACKNOWLEDGEMENT

Please read the following information carefully, and **initial each box before signing document**

Insurance Authorization

Initial

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/ or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Tekwani Vision Center. Therefore I will be financially responsible for all charges assigned to my visit. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Financial Responsibility

Initial

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage for the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. This amount may include a refraction fee of $29.00 for checking eyeglass prescriptions. **In the event of non-payment, you will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.**

Privacy Notice (HIPPA)

Initial

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting one.

I have read all of the above terms and hereby assume responsibility for paying any charges according to these terms. I also attest that the information listed is true and accurate to the best of my knowledge.

Signature: _____
Print Name: _____
Date: _____

HIPPA APPROVED CONTACTS

First Name	Last Name
Relationship	Contact Phone Number

First Name	Last Name
Relationship	Contact Phone Number

I give permission for Tekwani Vision Center to discuss/released protected health information with the above approved contacts. Changes may be made to this list at any time in person or in a written document.

Signature: _____ Date: _____