PRIMARY EYE CARE CENTERS

Insurance Authorization and Release of Information

I hereby authorize my physician(s) and his/her designee(s) to release and disclose such medical records, information, and documentation, as may be necessary or appropriate in order to process insurance claims and to obtain payment on my behalf. I also authorize the release of information acquired in the course of my examination or treatment and all information pertaining to my history and progress of my case. I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

ASSIGNMENT In consideration for health care services/material purchases provided to me by Primary Eye Care Centers, p.c., I here assign to my Physician(s) all of my insurance benefits for physician care and related services to which I may be entitled according to my policy of insurance with all my insurance companies.

WHEN INSURANCE COVERAGE IS INSUFFICIENT In the event the insurance benefits which have been assigned hereunder to my physician(s) are insufficient to pay for all the health services provided to me, I understand that I will be fully responsible for payment of balances due (or my physician's total charge in the event the insurance benefits are not paid to my physician(s). I also understand if payment is not made to the physician or billing company used by the physician (for services and materials submitted to insurance or not submitted to insurance) in a timely manner (60 days) and I am sent to collections, I am also responsible to pay the original fees plus any or all collection fees, lawyer expenses and court costs associated with collection of what is owed to the physician or billing company. I also understand that eyeglasses are medical devices and once ordered are non-refundable and I will be responsible for payment in full. I acknowledge that this signed document does not expire and applies to any insurance changes from original date of signature to current appointment/service.

MEDICAL RECORDS I understand that my medical records, including any alcohol or drug abuse data may be protected by Federal Regulations- 42CFR Part 2. I authorize release of my medical records including any information regarding drug and alcohol abuse.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a COURTESY that we extend to our patients, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____
Patient name (Printed)	Date of Birth	Patient/Legal Guardian Signature
_____	_____	
Legal Guardian Name (Printed) (under 18)	Date	

HIPAA Family/Patient Information Release Form

In compliance with the new HIPAA law, any person that is **age 18 years or older** are required to give written permission to their medical care providers to release information regarding:

Please **initial** the ones you are approving.

_____ Their private billing account ledger, including all charges and all balance amount with Primary Eye Care Centers and or their billing firm. (verbal or written)

_____ Any information regarding their insurance account with **Primary Eye Care Centers** including all charges, testing, balance and conversations or explanation of benefits from any insurance carrier/s and/or their billing office (verbal or written).

_____ Any information pertaining to my medical treatment and diagnosis (verbal only)

_____ Copies of my complete medical files (written only).

_____ Permission to pick up my eyeglass prescription (written only) and/or any items such as eyeglasses or contacts that have been ordered and are ready for pick up.

By signing this form, I am giving permission to release only the specific information **"initialed"** above regarding my account and/or my medical records with Primary Eye Care Centers, p.c./and or their billing company to the following person/s listed below.
I also understand that I may rescind this permission at any time with written notice to Primary Eye Care Centers, p.c.:

_____/_____	
Name	Relationship
_____/_____	
Name	Relationship

_____	_____	_____
Patient Signature	Date	Office Personnel (Witness)