GERRY OPTICAL COMPANY

NOTICE OF PRIVACY PRACTICES - HIPPA CONSENT

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services, and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance had changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office my Medicare ID card.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not effect any disclosures already made in compliance with my prior consent. Gerry Optical Company provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

_____ _____

Printed Patient Name (and Guardian Name if applicable) Date

_____ _____

Patient or Guardian Signature Date

I give permission to communicate my private healthcare information to:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship