Optics Plus Vision Center
224 Chestnut Street, Coshocton, Ohio 43821
(740) 622-1484

Charles W. Fornara, O.D.

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment, and payment activities.

I authorize Optics Plus Vision Center to release my medical records to my primary doctor and/or to the doctor who referred me. I also authorize the release of my personal information to my insurance company for the purpose of processing any claims on my behalf. Additionally, I authorize Optics Plus Vision Center to request/obtain a copy or summary of my medical records, including medication list, from my other healthcare providers.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and discuss your PHI.

Patient's Consent

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

e-mail _____ Soc. Sec. #_____ - _____ - _____

I, _____, have read your Notice of Privacy Policies and consent to your use of my PHI for the purpose of healthcare operations, treatment, and payment activities.

Signature _____

If this form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. The revocation also does not negate any of our prior actions while acting under your consent.

Signature _____ ***Date*** _____

Please complete the following if signed by a personal representative:

Personal Representative's Name: Relationship to Patient:

_____ _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____ , have received a copy of Optics Plus Vision Center's Notice of Privacy Policies.

_____

Name (print)

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship to Patient

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DEAR PATIENT: *We will bill your insurance company as a courtesy to you. Please make sure that we have your current insurance information on file. This will enable our office to file your insurance claims with correct information. Incorrect information will result in a denied claim.* ***(Denied claims become your responsibility to re-file with your insurance company and your responsibility to pay.)*** *We will wait up to 60 days for the insurance company to remit payment. If it is not paid within this time, the total bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance company to expedite payment. Please forward any information they may request.* _____ **Please initial**

I acknowledge full financial responsibility for services rendered and I agree to pay my balance at the time of service or to make prior arrangements for payment.

I understand that there will be a **$30.00** charge for all returned checks. I further acknowledge that after 60 days, interest may accrue on any unpaid balances on my account and/or my account may be turned over to collections.

I request that the payment of benefits be made on my behalf to Optics Plus Vision Center for any services furnished me by their providers.

***Cancellation/No Show Policy:** We require 48 hours advance notice if you need to cancel or reschedule an appointment for any reason. If this is not done, then your appointment will be counted as a "no show." If you have two (2) "no shows" within a 12 month period, then our No-Show Policy goes into effect. Under this policy, you have the option of being examined on a "walk-in" basis only (subject to availability), or you may pay a $25.00 deposit to hold a new appointment time for you. If you keep this new appointment, then the deposit will be refunded in full. Or, you may apply it toward any outstanding account balance that you may have.

***Scheduled Appointments:** We understand that delays can happen, however we must try to keep the other patients and the doctor on time. If a patient is 10 minutes past their scheduled time we may have to reschedule the appointment.

***Account Balances:** We require that any co-payments and deductibles that you are responsible for are due and payable on the date of your examination. We also require that we collect a down payment of 50% of your balance on any eyeglasses or contact lenses prior to ordering them. Any remaining balance must be paid in full on or before any eyewear can be dispensed.

Printed Name: _____ **Signature:** _____ **Date:** _____

How will you be paying for your portion of today's visit?

Cash ____ Check ___ Credit/Debit Card _____ _____ **Please initial**

Thank you! We appreciate your patronage and your patience.