HIPAA ACKNOWLEDGEMENT

_____ PATIENT PRIVACY PRACTICES:

Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____ CONSENT TO TREATMENT AND RECORD RELEASE AUTHORIZATION:

Initials

I authorize Eye Physicians Medical/Surgical Center, Inc. to evaluate and treat me or my family member. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies. I hereby authorize Eye Physicians Medical/Surgical Center, Inc. to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and plastic surgery care.

_____ OPEN PAYMENT DATABASE WEBSITE:

Initials

The open payment database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at **https://openpaymentsdata.cms.gov.** Please let the front desk know if you would like a copy of your paperwork.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for Eye Physicians Medical/Surgical Center, Inc. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Eye Physicians Medical/Surgical Center, Inc. to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X _____ _____

Patient or Guardian Signature Date

_____ TELEPHONE CONSUMER PROTECTION ACT (TCPA):

Initials

I agree that the facility, Eye Physicians Medical/Surgical Center, Inc. or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voicemail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____ FINANCIAL RESPONSIBILITY:

Initials

Payment Authorization and Release of Information

I (refers to the undersigned throughout this document) understand that all fees incurred are the responsibility of the patient, patient's parent, patient's legal guardian, and/or authorized agent, and I acknowledge responsibility for any and all charges billed to me for medical and surgical services rendered to myself and my family. I further acknowledge that insurance companies are billed as a courtesy to the patient.

I authorize Eye Physicians Medical/Surgical Center, Inc. to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination tendered to me during the period of such medical care.

I hereby authorize any health insurance company(ies) insuring me and my family members to pay Eye Physicians Medical/Surgical Center, Inc. for medical and surgical services rendered to the above named patient.

I understand that Eye Physicians Medical/Surgical Center, Inc. will NOT bill any insurance company for procedures considered cosmetic unless there is prior authorization. If I wish to bill for my surgery I MUST wait to have the surgery until after authorization from my insurance company has been obtained by Eye Physicians Medical/Surgical Center, Inc. Should I choose to have my surgery before authorization, Eye Physicians Medical/Surgical Center, Inc. will not assist in any way billing for insurance purposes.

X _____ _____

Signature Date

Patient Signature: _____

Spouse/Parent: _____

Phone: (_____) _____

Responsible Party if other than patient: _____

Phone: (_____) _____