

# Hipaa Form

## AUTHORIZATION & ACKNOWLEDGEMENT

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Patient Name \*

First

Last

Phone \*

Email

**Parents, if your child is under the age of 18, please sign for the following**

We are proud to offer the latest technology for your eye exam, the **OPTOS DAYTONA**. The Optos Daytona is a retina imaging system that offers an ultra-wide digital image of the inside of your eye, called an **OPTOMAP**. This is done ***without the use of dilating eye drops***. This image allows the doctor to view approximately 80% of the retina inside your eye, and makes it possible to diagnose eye disease early and more thoroughly. This scan becomes a permanent part of your medical file which allows accurate comparisons at each yearly eye exam. **Our doctors believe the OPTOMAP to be an essential part of your eye exam and prescribe it for all patients once a year.**

**Depending on the results of your Optomap, the doctors will determine whether your eyes will be dilated. The OPTOMAP screening is not covered by most insurance and a \$39.00 is charged for this service.**

- Yes, I want to have an Optomap retinal image taken of my eye.
- No, I do not wish to have an Optomap retinal image taken at this time, Dilation is okay.
- I would like to discuss my options further before deciding.

## Release of Information

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I hereby authorize Atkinson Eye Care to release my information necessary to my insurance company to expedite claims for payments. I authorize the release of medical information for the purpose of patient referral should I be referred to another physician.

## Patient Financial Agreement

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- I agree to be responsible for my financial portion of today's services including copays, deductibles & all non-covered procedures I elect to have performed. A copy of the financial statement is available to me upon request.
- We do not contract with any HMO's for medical eye care. If you are an HMO member, you should assume all HMO insurance is NOT accepted by our office and that payment for services will be due on the day of your visit. If you are an HMO insured patient you may elect to see us and pay for our services directly or see your HMO primary care physician for a referral to an In-Network provider for care instead.

## About Your Insurance

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There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Atkinson Eye Care accepts insurance plans in both categories: 1) Vision plans (such as VSP and EyeMed) and 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance must be used for medical eye care.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

Patient/Parent signature \*



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If discussed, I authorize the provision of medical services which are determined by Atkinson Eye Care to be in my best interest of care other than those I have previously refused in writing.

## Notice of Privacy Practices

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I have reviewed the Atkinson Eye Care Privacy Notice that describes how my information may be disclosed. A copy of this notice is available to me upon request.

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## **Patient Portal**

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I confirm I have received access to the Atkinson Eye Care online Patient Portal where I can obtain my Prescriptions, Health Information, and Account Information.

### **Patient/Parent Signature**

A large, empty rectangular box with a dashed border, intended for a signature.