NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAYs

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service for Dr. Mona Patel OD, LLC (The Eye Studio).

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Dr. Mona Patel OD, LLC (The Eye Studio).

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Dr. Mona Patel OD, LLC (The Eye Studio) or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), of which I can request a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

PATIENT/GUARDIAN ACKNOWLEDGMENT AND AGREEMENT

Patient Name (Print) _____

Patient Signature_____

*** If patient is a minor: I attest that I am the legal guardian with legal authority to make medical decisions for this minor**

Name of Legal Guardian _____ Guardian Signature_____

Date_____ Witness_____