

Notice of Patient Privacy Rights, Protection & Responsibilities

Thank you for choosing Woodbine Eye Care for your vision care needs. Our goal is to provide excellent care and service. Please take a moment to review our Notice of Privacy Practices (HIPAA) and our Financial Policy, which outline how your information is used and your responsibilities regarding payment.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided 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 operations such as quality assessments and physician certifications.

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 or Woodbine Eye Care.

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 the provider of service or Woodbine Eye Care.

INSURANCES

We participate with many insurance plans and vision plans. As a courtesy, we will verify eligibility and file claims on your behalf. However, it is your responsibility to: provide accurate and current insurance information, understand your benefits and coverage, and pay for services not covered by your plan. Contact lens evaluations are separate from routine eye exams and may not be covered by your insurance, depending on your plan. Vision insurance typically covers routine eye exams and eyewear. Medical insurance is used for non-routine exams such as red eyes, glaucoma, or diabetes-related eye exams.

For Medicare patients: I authorize Woodbine Eye Care to release any medical information necessary to process my Medicare claims. I request that payment of authorized Medicare benefits be made on my behalf to Woodbine Eye Care. I understand that I am responsible for the Medicare deductible, coinsurance, and any non-covered services.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service including: co-pays, deductibles, coinsurance, services not covered by insurance, eyewear purchases, and eyewear materials. Woodbine Eye Care accepts cash, credit/debit cards, and HSA/FSA cards. Woodbine Eye Care uses a secure payment system that allows us to safely charge your credit card without storing your card number. Your payment information is encrypted and protected. With your permission, this information may be used for future payments on your account, such as co-pays and outstanding balances. You will receive notice before any charge is processed, and this authorization will remain in effect for future visits until you revoke it in writing.

All eyewear purchases are final once orders are placed. Contact lens evaluations are separate from a routine eye exam and might not be covered by your insurance depending on your plan. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Woodbine Eye Care or my insurance carrier responsible for accidental laboratory breakage or damage. 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. Balances not paid within 30 days may be subject to interest and collection fees. Please contact us if you need to arrange a payment plan.

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 lens 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.

I have read and consent to the privacy practices and financial policy.

Printed Name:

Signature (*Patient or Guarantor*):

Relationship to Patient (*if not self*):

Date:
