

Lisa M. Nath MD
Eye Physician and Surgeon

Financial Policy, Consent, and HIPPA Acknowledgment

- **Insurance Billing:** I consent for the practice to bill my insurance company according to the most recent insurance information and insurance card(s) including, Medicare and Medicaid Advantage plan cards that I have provided. I understand that all balances are my responsibility, including co-pays, co-insurance amounts, deductible amounts, and services that are not covered by my insurance plan (such as cosmetic services). I understand that if claims are denied due to lack of insurance information I will be responsible for the balance.
- **Insurance Network:** I understand that it is my responsibility to ensure that the practice and provider of services are in my insurance network and obtain any referrals or authorizations required by my insurance plan. If my claim is denied because I am out of network or failed to obtain a referral or authorization I understand I will be responsible for the balance.
- **Co-payment:** I understand all co-payments must be paid at time of service. I understand co-payment, and co-insurance are determined by my insurance. The practice accepts cash, checks, Visa, Mastercard, Discover, American Express, and Care credit.
- **Deductible:** An annual deductible is a dollar amount set by my insurance that I must pay out of pocket each year before my insurance starts to pay.
- **Credit Card on File:** For any prearranged payment plans, the practice will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is completely compliant as required by law.
- **Determining Guarantor:** The guarantor is the responsible party held accountable for the patient's bill. The guarantor is usually the patient if they are over the age of 18. If the patient is a minor the guarantor is the parent or legal guardian.
- **Self-Pay:** I understand and agree that if I do not have insurance or opt out of insurance coverage if permitted and elect to be seen as self-pay patient, I have full financial responsibility for my visits and will pay for all services at the time of service, unless other arrangements have been made. I understand I will be subject to and will abide by the practice's self-pay policy. This agreement will remain in effect unless proof of insurance is provided at a subsequent date.
- **Good Faith Estimates:** If I am uninsured, or if I request that covered services not be billed to insurance, I understand that I may request a Good Faith Estimate of the total fees that I may be charged and that fees for all services must be paid on the date services are rendered.
- **Past Due Balances:** I understand that if my account is over 90 days past due, this practice will send a statement and/or letter as well as contact me via phone. I will have 20 days in which to pay the balance in full. Partial payments will not be accepted unless previously negotiated. I understand that if the balance remains unpaid this practice may refer my account to a collection agency and/or I may be dismissed from the practice.
- **Late Arrivals or Missed Appointments:** I am aware that if I am late to my appointment I may be rescheduled. I also understand that multiple missed appointments without adequate notice and/or late arrivals may result in dismissal from the practice. If I am unable to keep my appointment I will notify the office at least 24 hours in advance. I understand failure to provide 24 hours notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is \$50 and is not billable to my insurance.
- **Prescription History:** I authorize this practice to request prescription history information electronically from my local pharmacy(ies) for the purpose of providing direct health care services unless otherwise revoked.
- **HIPPA Disclosure and Notice of Privacy Practices:** I consent for the practice to release information

to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPPA Privacy Act. I understand that medical information disclosed may be used and forwarded to provide continuing treatment or care, for filing claims, and for all other healthcare operations. I have received this practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have had the right to review such notice prior to signing this consent form.

- **Use of my Contact Information:** I understand the practice may use my information to contact me regarding my treatment, appointment reminders, test results, billing matters, and payment, including through voicemail messages, text messages, and email. I understand I can revoke this authorization at any time in writing to the practice.
- **Disclosure of Information to Others:** I have been given the opportunity to list and update in writing someone I would like list as an emergency contact as well as to speak to on my behalf. Listed below are any changes made to these contacts. I understand if I have left this information blank the current contacts listed for me will remain the same. I understand it is my responsibility to notify this practice if there are changes to those that may participate in my care.

Name and relationship

Phone Number

Name and relationship

Phone Number

My signature indicates that I have been given the opportunity to review this information, ask questions and have had my questions answered. I understand that I am financially responsible for all services as described in this consent form.

Patient Signature

Today's Date