

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

LOOKING GLASS EYE CENTER, PA

Brevard Office

188 Medical Park Drive, Suite C
Brevard, NC 28712
828-884-7320

Hendersonville Office

215 Thompson Street
Hendersonville, NC 28792
828-693-4161

Cashiers Office

Hwy 107 South
Cashiers, NC 28717
800-635-7955

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been presented the opportunity to read or have requested and been given a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at one of the addresses above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

| | | |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|

OVER PLEASE

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR HEALTH CARE. IN ORDER TO ASSIST YOU IN UNDERSTANDING AND MANAGING YOUR RESPONSIBILITIES AS A PATIENT IN OUR OFFICE, WE HAVE DEVELOPED A FINANCIAL POLICY, AS WELL AS SOME GENERAL OFFICE POLICIES WHICH WILL HELP PREVENT UNNECESSARY INCREASES IN YOUR MEDICAL BILLS. PLEASE READ AND SIGN THIS POLICY PRIOR TO YOUR VISIT WITH OUR PHYSICIAN.

- OUR OFFICE REQUIRES THAT YOU FULLY COMPLETE A PATIENT INFORMATION FORM, WHICH INCLUDES ALL CURRENT INSURANCE INFORMATION FOR THE PATIENT PRIOR TO BEING SEEN IN OUR OFFICE.
- PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. WE ACCEPT PERSONAL CHECKS, CASH, VISA, MASTERCARD, AND DISCOVER. LOOKING GLASS EYE CENTER WILL EXPECT FULL PAYMENT OF COPAYS OR COINSURANCE AT THE TIME OF SERVICE IF YOUR VISIT IS COVERED BY AN INSURANCE PLAN WITH WHICH WE PARTICIPATE.
- IF YOU HAVE A UNIQUE FINANCIAL PROBLEM, PLEASE DISCUSS THIS WITH OUR MANAGEMENT.
- PLEASE BE ADVISED THAT LOOKING GLASS EYE CENTER WORKS WITH A PROFESSIONAL COLLECTION AGENCY AND ANY UNPAID ACCOUNTS WILL BE GIVEN TO THIS AGENCY FOR COLLECTION EFFORTS. THIS WOULD AFFECT YOUR CREDIT RATING AND SHOW ON YOUR CREDIT REPORT.
- PLEASE UNDERSTAND THAT YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU MAY BE RESPONSIBLE IF YOUR INSURANCE COMPANY DOESN'T MAKE PAYMENT WITHIN A REASONABLE PERIOD OF TIME.
- THE ADULT PARENT OR GUARDIAN ACCOMPANYING A MINOR TO OUR OFFICE WILL BE REGARDED AS RESPONSIBLE FOR ALL BALANCES AND TRANSACTIONS FOR THE PATIENT.
- MEDICAID PATIENTS MUST PRESENT A CURRENT MEDICAID CARD AT THE TIME OF THEIR VISIT. ADULTS WILL BE EXPECTED TO HAVE THEIR \$3.00 COPAYMENT AT THE TIME OF THEIR VISIT. YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU DO NOT PRESENT A CURRENT MEDICAID CARD.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY. I ACCEPT THE TERMS OF THE POLICY.

SIGNATURE: _____ DATE _____

OVER PLEASE