Conditions for Treatment and Collection of Payment

I HEREBY AUTHORIZE Scottsdale Eye Physicians & Surgeons, P.C. to examine and treat me or the individual for whom I am responsible. If I am receiving a "vision exam" only, I understand this is not a comprehensive eye examination for eye diseases. During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause blurred vision and glare for several hours. I understand that driving an automobile or operating machinery is not advised until the effects of the drops have worn off.

I understand it is my responsibility to obtain prior authorization for my visit with Scottsdale Eye Physicians & Surgeons, P.C. if required by my insurance plan. I understand I have the primary responsibility for payment of my charges unless the doctor has a contract with my insurance plan that prohibits them from billing me directly for "covered" services. Some services performed by Scottsdale Eye Physicians & Surgeons, P.C., such as after-hours services, some tests, and refractions, may not be "covered" or reimbursed by my insurance company. I understand I will be responsible for payment of any of the following: "non-covered" services, co-payments, unmet deductible amounts, collection fees, if appropriate authorization was not obtained from my insurance company prior to the examination, and if I am no longer covered by the insurance plan I listed.

Unpaid balances over 90 days from the date of service will accrue a charge of 1.5% interest per month on the total balance for amounts greater than $500. Unpaid balances over 90 days for balances under $500 will be charged $15 rebilling fee per month.

I promise not to post on social media or the internet any unauthorized, undisclosed recordings taken in this office, which may include confidential information or matters taken out of context.

Scottsdale Eye Physicians & Surgeons, P.C. is required to submit a completed insurance form to Medicare and some insurance plans. Insurance guidelines permit them to obtain a one-time signature that is valid for this and future visits to their office. I understand that by signing below, the notation "SIGNATURE ON FILE" will appear in lieu of my signature on Medicare and other insurance claim forms submitted for me by this office.
I authorize Scottsdale Eye Physicians & Surgeons, P.C. to release information acquired in the course of my examination and treatment to my insurance carriers and other medical providers.

_____

Printed Patient Name

_____ _____

Patient (or Legal Guardian) Signature Date

HIPAA Privacy Authorization Notice
Scottsdale Eye Physicians & Surgeons, PC

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my personal health information.

A copy of the ***Notice of Privacy Practices*** has been made available for my review. I understand the office will use and disclose my protected health information to provide my medical care, receive payment for services provided to me, and to conduct its business.

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I authorize Scottsdale Eye Physicians & Surgeons, PC (SEPS) to communicate with me by any means of contact I have provided. For example, I may be contacted for appointment reminders, test results, satisfaction surveys, etc.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____
Printed Patient Name

_____ _____
Patient (or Legal Guardian) Signature Date

PRACTICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment of the Patient receipt of ***Notice of Privacy Practices*** but was unable to do so as documented below:

Date: _____ Reason: _____ Initials: _____