

**101 Eastern Boulevard North**

**Hagerstown, MD 21740**

**(240) 420-8888**

**CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION**

1. **Consent for Health Care Services:**  I authorize consent for medical treatment at Eyecare Professionals.
2. **Authorization for Release of Information:** Eyecare Professionals may release information from my medical records to any health care provider involved in my care and treatment. Eyecare Professionals may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, and the Medicare programs.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Eyecare Professionals which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If a payment is not made within 90 days from the date the bill was mailed from Eyecare Professionals, I understand that a delinquent charge of interest at the rate of 15% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be refunded in the same way as the original payment. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorization and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Eyecare Professionals charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance benefits for health care services or goods may be made directly to Eyecare Professionals.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment and I will be charged a $35.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be charged for that day.
7. **Charge for Refraction:** I understand that a refraction may be necessary for the doctor to fully evaluate my condition and I will be charged $59.00 for this service by Eyecare Professionals. I also understand that I will be responsible for this charge and that my insurance company will not be billed for this service.

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Notice of Privacy Practices from Eyecare Professionals.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

**Authorized Individuals:** These individuals are allowed to have information concerning my health conditions.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARD ON FILE PROGRAM**

Changes in our health care system and insurance policies have forced us to change all aspects of how we provide services to our patients. We have implemented a Credit Card on File payment system to provide a convenient way to pay your bill. This will allow our office to deliver a simpler, faster and more efficient bill pay system. The advantage to you is that you no longer need to write out checks or send payments in the mail. This reduces paperwork and ultimately helps lower the cost of healthcare.

**HOW IT WORKS**

Patients with insurance sign a consent form annually for card on file services, provide a credit card at initial check in before office visit, which we scan into our system. The information is held securely on an encrypted site.

Once we receive your **Explanation of benefits (EOB),** it notifies us of any additional amount owed by you. This is the **Patient Responsibility.**  At that time, we will notify you that the remaining balance owed will be charged to the credit card. At the patient’s request a copy of the statement can be emailed or mailed. We will attempt to contact you out of courtesy to let you know the card is going to be processed. If we cannot reach you, we will charge the authorized card on file.

Storing your credit card on file with us will not compromise your ability to dispute charges or question your insurance company’s determination of payment. We accept Visa, MasterCard, Discover, and American Express. Health Reimbursement cards may also be used as card on file as long as there is a current balance.

**Patients without health insurance, or who choose to opt out of the card on file program, are required to pay for services and materials in full the day of service/order.**

**I acknowledge that:**

* **I am opting in to the Credit Card on File Program**
* **I have read this form and understand its contents.**
* **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
* **I am responsible for the payment and/or copayment that is due at the time of service.**
* **I have received a copy of Eyecare Professionals HIPAA policy.**

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Signature of Patient or Legally Responsible Person Name (Please print)

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Relationship Date