Eye Care of Claremore Privacy and Billing Procedures
Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Eye Care of Claremore in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Eye Care of Claremore

Acknowledgement of Receipt of Notice of Privacy Practices

Authorization to Release Information to Family/Friends or Others

I have received a copy of Eye Care of Claremore's Notice of Privacy Practices. I authorize Eye Care of Claremore to release any information regarding my treatment and medical records to the following individuals/entities (Eye Care of Claremore may not release information to the names individuals/entities unless you identify them here:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Eye Care of Claremore will use my home/cell phone number and primary address supplied during registration to contact me regarding my treatment and medical records. I will ensure this information is up to date at every visit.

Authorization to Treat and Bill

I consent to be treated by Eye Care of Claremore. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Eye Care of Claremore to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Eye Care of Claremore, or to outside labs as described below, for all services performed and billed by Eye Care of Claremore. I understand that I am responsible for all charges for the treatment I receive at Eye Care of Claremore. I understand that Eye Care of Claremore providers may utilize the Prescription Drug Monitoring Program service at no additional charge to me.

As a courtesy, Eye Care of Claremore will bill my medical insurance. If I do not provide complete and accurate insurance information to Eye Care of Claremore, I understand that Eye Care of Claremore may not receive payment from my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Eye Care of Claremore bill, I may owe Eye Care of Claremore payment for services not covered by my insurance and I agree to pay these charges promptly to Eye Care of Claremore. I understand that my medical insurance may not pay for all services and I agree to pay any remaining balance promptly.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service. Eye Care of Claremore may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay Eye Care of Claremore for services provided to me, the balance owed may be sent to collection and I may incur collection fees in addition to the amount owed for services/treatment rendered.

Signature: _____ Today's Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

Name of Patient Representative: _____ Relationship to Patient: _____

***Patient Representative Information is Required if the Patient is a Minor ***