Evans, Piggott & Finney Eye Care Group HIPAA/Check-In Form

Patient Name: _____Date: _____

Please read all statements completely and sign below.

HIPAA

I, _____, have been presented a copy of the HIPAA privacy act. I have read it and understand the content. I know that at any time I can request my own copy of the form.

Authorization of Use and Disclosure of Protected Health Information

I, _____, authorize Evans, Piggott & Finney Eye Care Group, doctors and staff; to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations. (List below Name of person or persons you authorize release of information to. You may revoke this right at any time.)

_____

_____

Evans, Piggott & Finney Eye Care Group is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Our doctors are trained to diagnose and treat most ocular diseases.

As a courtesy to our patients, we are happy to file with your insurance company. NOTE: The patient is responsible for any co-pays and/or deductible which your insurance requires.

ROUTINE VISION EXAMS will be filed with a patient's Vision Plan, if you have one. A routine exam means there is **not** a medical diagnosis. Routine diagnosis is myopia (near-sightedness), hyperopia (far-sightedness), astigmatism and presbyopia.

If a ***MEDICAL DIAGNOSIS*** (cataracts, glaucoma/glaucoma suspect, diabetes, pink eye-conjunctivitis, foreign body, dry eye syndrome, etc.) is determined by the doctor during patient's exam, it is no longer routine, but medical. This means we will bill your Health (Medical) Insurance. We request a copy of your medical card in your chart for these reasons.

***( )** I have read and understand when my **VISION PLAN** will be billed and when my **MEDICAL INSURANCE** will be billed by Evans, Piggott & Finney Eye Care Group.

Consent of Treatment: I hereby grant MY authorization and consent for medical treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as to the results that may be obtained.

Authorization: I authorize the doctor to release any information including diagnosis, records of treatment or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or group, insurance benefits otherwise payable to me. I understand my insurance may pay less than the actual billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I, _____, have read and understand all of the above information.

_____ _____ _____

Signature of Patient or Guarantor Relationship Date