

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION	As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services. I acknowledge that having an authorization from my vision insurance carrier does not assure eligibility.
MEDICAL NECESSITY	If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.
BILLING & COLLECTIONS POLICY	<p>Payment for all services is due at the time services are rendered, including applicable copays. Co-payments cannot be waived at any time by the provider of the service or Bright View Family Vision. It is your responsibility to know your benefits, copays and out of pocket costs. You authorize Bright View Family Vision to file for your vision and medical benefits on your behalf and to receive payment for services rendered.</p> <p>Accounts that are 30 days past due will be assessed a \$15.00 Late Fee. Accounts that are over 60 days past due will be assessed a \$35.00 Late Fee. Any account over 90 Days will be assessed a \$50.00 Late Fee and be turned over to our collection agency, where the balance will be subject to additional fees. If you are unable to pay your balance, please contact our office to work out a payment plan.</p>
DEDUCTIBLES	If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, not more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Bright View Family Vision.
	<p>I understand that I am responsible for 100% of all professional fees rendered on the date of service. If I am supplying my own frame that many plastic and metal products may weaken over time and I will not hold Bright View Family Vision or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.</p> <p>Our patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues a no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.</p>
HIPAA	I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of our Notice of Privacy Practices. 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, and conduct normal healthcare operation such as quality assessments and physician certifications.

Signature below is an acknowledgement that you have received this Notice of Patient Privacy Rights, Protection, and Responsibilities

Patient Signature/Guarantor	Date:
Print Name:	

Please list anyone that you would like us to be able to release your protected health information to or be able to discuss your protected information with.

Print Name:
