EYE CARE CENTER
OF NEWTON

HIPAA Authorization

The Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement of Receipt of Notice of Privacy Practices.

In order to provide services to you, the patient, Newton Family Eye Care, P.C. will collect private information that identifies you. We will receive, create, and store your protected health information. It is often necessary for us to use and disclose your health information to treat you, obtain payment for services, and conduct healthcare operations in our office. The Notice of Privacy Practices describes these uses and disclosures in detail.

I acknowledge that I have been informed of the Notice of Privacy Practices. Initial: _____

I acknowledge that I may request a copy of the Notice of Privacy Practice at any time. Initial: _____

Signature on File

I request that payment of authorized Medicare or other medical insurance benefits be made either to me or my behalf to Newton Family Eye Care, P.C. for services furnished to me by the provider. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services or other insurance carriers and its agents. Any other information needed to determine these benefits or the benefits payable for related services will also be released. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be valid as the original.

Initial: _____

If our office accepts assignments from your medical insurance provider or vision care plan, we will be billing your medical insurance company or vision care plan for fees for your office visits and/or materials. If you are denied benefits for any reason, you are responsible for any unpaid fees for these services and/or materials

By initialing below, you acknowledge that you are financially responsible for all charges incurred which are not covered by your medical insurance or vision care plan.

Initial: _____

Eyeglasses and Contact Lens Prescription

I acknowledge that I am able to access, download and print a digital copy of my eyeglasses and contact lens prescriptions through Eye Care Center of Newton's secure online patient portal. I also understand that I can call Eye Care Center of Newton during regular office hours to request or reset my username and password for the online portal. I authorize Eye Care Center of Newton to electronically send my prescription to my online patient portal. I will be provided a printed copy of my eyeglasses or contact lens prescription at my request.

Initial: _____

By signing below, I acknowledge that I agree to the HIPAA Authorization, Signature on File and Eyeglasses and Contact Lens Prescription Release Agreement

Signature: _____ Date: _____