

## Duplin Eye Associates

### Insurance Payment and Privacy Statement

Thank you for choosing Duplin Eye Associates for your eyecare needs. We have developed this comprehensive payment and privacy policy form in accordance with HIPAA guidelines. This form must be signed and dated on the back at each encounter.

- ◆ Duplin Eye Associates accepts assignment (payment) from several insurance carriers. Our staff will assist you in determining your benefits for today's charges.
- ◆ Proof of current insurance, co-payments, and/or examination fees is due at time of service.
- ◆ If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 90 days, we will expect payment in full if your insurance company has not paid or we have not heard from your insurance company.
- ◆ We are obligated to release information including the name of the patient and responsible party, home address, phone number, date of birth, place of employment, and certain specifics of your condition and treatment to your insurance company for payment of your claim.
- ◆ At times, we are required to submit medical records for review by insurance companies to guard against fraud and to make sure we comply with HCFA guidelines. Only **your** insurance company has permission to see your medical records and personal information.
- ◆ Claim submission is either sent via US Mail, password-protected encrypted Internet Website, or direct-connect to insurance vender's secure server.
- ◆ Generally, payment of claims is made by check and sent via US Mail. Accompanying the check is, usually, an explanation of benefits, which contains a summary of the claim.
- ◆ Duplin Eye Associates only uses your personal information to send statements of account, spectacle or contact lenses, and appointment reminders. If you prefer to have reminders sent in an envelope, please let us know.
- ◆ We will not release or sell your personal information to anyone or any company to be put on a mailing list to receive promotional information.
- ◆ All information stored in our computer system can only be accessed by computers within the building. Password protection blocks any unauthorized in-office access. External access is unavailable because office computers do not receive any incoming inquiries.

#### **By signing on the reverse of this form, you agree to the following statements:**

- I hereby authorize my insurance carrier to make payment directly to Duplin Eye Associates for any and all services rendered to me by Duplin Eye Associates. I understand that **I am responsible for all charges whether or not covered by insurance.**
- I release any information regarding my treatment or condition in order to obtain payment for professional services.
- I authorize the use of this form in all my insurance claim submissions.
- I understand that I will be responsible for filing with my insurance company if Duplin Eye Associates does not accept assignment of today's charges.
- I permit a copy of this authorization to be used in place of the original document.
- I authorize you to give me reasonable and proper medical care, in my best medical interest, by today's standards.

--- SIGNATURE OF PATIENT OR AUTHORIZED PERSON ---

PLEASE READ COMPLETELY THE REVERSE SIDE OF THIS DOCUMENT BEFORE SIGNING.

By signing on this form, you agree to the statements the reverse of this form:

PATIENT'S NAME (PRINT) \_\_\_\_\_

RESPONSIBLE PARTY (PRINT) \_\_\_\_\_

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