The content below is **not the actual consent form, simply a copy for your reference. **

If you desire to sign this consent form prior to your upcoming appointment, you can locate the official consent in the New Patient Form section of this website.

NOTICE OF INFORMATION PRACTICES

1) Piedmont Eye Center, Inc. may use and disclose protected health information for treatment, payment, and healthcare operations. Examples: referrals, nursing homes, pharmacies, hospital referrals, drug assistance programs, and low vision rehabilitation programs. Payment examples include: insurance companies and collection agencies. Healthcare operations include: electronic billing and auditing medical records.

2) In certain circumstances under state and federal laws, Piedmont Eye Center, Inc. is required to disclose protected health information without the individual's written consent or authorization. An example of such are for public health requirements or court orders.

3) Piedmont Eye Center, Inc. will not make any other use or disclosure of a patient's protected health information without the individual's written authorization.

4) Piedmont Eye Center, Inc. reserves the right to change the terms of its notice and to make new provisions effective for all protected health information that it maintains.

5) Any patient, guardian or personal representative has the right to request, inspect and obtain copies of his/her medical record, request amendments be made to his/her medical record, request to receive confidential communications of protected health information by alternative means or at alternative locations, request a six-year accounting of all disclosures of his/her medical records and to request restriction as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.

6) All such requests must be in writing and the practice must accommodate reasonable request.

7) Any person/patient may file a complaint with the Practice and with the Secretary of Health and Human Services if he/she believes his/her privacy rights have been violated. No retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

effective date: 08/13/2013

CONSENT FORM

(For use and disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that my health information serves as: A basis for planning my care and treatment, a means to communicate among health professionals, a source of information for applying my diagnosis to my bill, a means by which a third party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provided a summary description on information uses and disclosures. I notice that I have the right to review the comprehensive notice on file with the practice, prior to signing this consent.

With this consent, Piedmont Eye Center, Inc. may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory and test results among others.

With this consent, Piedmont Eye Center, Inc. may e-mail to me appointment reminders and patient statements. I have the right to request that Piedmont Eye Center, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if it does, it is bound to this agreement.

By signing this form, I am consenting to Piedmont Eye Center, Inc. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this form, Piedmont Eye Center, Inc. may decline to provide treatment to me.**

Please provide a list of relatives, spouse, friends, care givers etc. that have your permission to access your health information if they should call our practice on your behalf. By law, we will not be able to disclose any part of your examination or billing information with any individual unless their name appears on your list. The caller will be asked to verify certain information about you prior to the disclosure of your protected information.
Piedmont Eye Center, Inc. has permission to discuss my healthcare and billing information with the following family members or other personal contacts, including spouse, friends, care givers, etc. (Please include name and relationship - or enter NONE)*

CONSENT TO OBTAIN MEDICATION HISTORY

Piedmont Eye Center has implemented ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians to begin prescribing electronically starting in 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

I agree that Piedmont Eye Center, Inc. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

YOUR FINANCIAL RESPONSIBILITY:

You are financially responsible for the services **Piedmont Eye Center** provides to you. We understand that many patients arrange for insurance companies to pay for a large portion of medical claims. However, the patient is ultimately responsible for the bill if the insurance company does not pay.

We provide two billing related courtesies to our patients:

1. We will contact your insurance carrier to request a pre-authorization/pre-determination for any planned treatments, if required by your insurer. It is important to understand that even if the insurance company provides authorization for treatment, it does not guarantee that they will pay once services have been performed.

For this reason, we strongly recommend you contact your insurance company directly to confirm what degree of payment you can expect from them based on your individual plan, and to confirm that any planned procedures are included in the plan you chose.

2. We will file a claim to your primary and secondary insurance plans.

All payments are due at check-in.

Expect to pay at the date of service; co-payments, coinsurance, deductibles, non-covered services, and if **Piedmont Eye Center** does not participate with your insurance, if you have a Vision Plan, or if you are uninsured. If you are unsure of your financial responsibility, please contact your insurance company in advance, to obtain this information. We reserve the right to reschedule your appointment if your co-pay is not paid at check-in.

Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Any balance remaining after insurance has paid their part of the covered portion will be due prior to the next appointment.

Non-covered services
Most medical insurance plans, including Medicare & Medicaid, do not cover fees associated with routine refractions, completing medical forms, reproduction of medical records, cancelled appointments and no-shows.

You must pay for these services in full.
Refraction is performed to establish a baseline of the patients best corrected visual acuity in addition to determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination for monitoring the health of the eye. Most medical insurance plans, including Medicare & Medicaid, do not cover routine refractions and allow that we charge separately for that portion of the examination, since it is not a covered service.

Missed appointments and no-shows
As a courtesy to our patients, we will call to remind you in advance of your upcoming appointment. Our staff will contact you at the telephone numbers you have provided 24-72 hours prior to your scheduled appointment.
A fee of $25 may be assessed to your account if 24 hour advanced notice is not given. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay in full prior to scheduling your next appointment.

A 24-hour notice of cancellation provides us with the ability to schedule patients on our wait list.

SIGNATURE ON FILE, ASSIGNMNET OF BENEFITS, FINANCIAL AGREEMENT:

1. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Piedmont Eye Center, Inc., for services furnished me by Piedmont Eye Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS- 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Piedmont Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP**: I understand that if MediGap policy or other health insurance is indicated in Item 9 of the CMS- 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Piedmont Eye Center, Inc., if possible or otherwise to me.

3. **RELEASE OF INFORMATION**: Piedmont Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Piedmont Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Piedmont Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE**: I understand that Piedmont Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Piedmont Eye Center has no contract, expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Piedmont Eye Center if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES**: I understand that Piedmont Eye Center contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are “covered” by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with a health care service plan or in the benefit summary the health care service plan furnishes the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Piedmont Eye Center to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by Piedmont Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Piedmont Eye Center for payment. I understand and agree that if my account becomes delinquent after three (3) months it is turned over to a collection agency. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Piedmont Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Piedmont Eye Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.